



FAMILY ASSISTANCE PROGRAM

Documentation of Pediatric Feeding Disorder (PFD) or Feeding Difficulties

Pediatrician Name _____

Office Name _____

Office Address _____

Phone Number _____

Date _____

To whom it may concern:

This is to confirm that _____ has been seen for a pediatric feeding disorder (PFD) or for feeding difficulties.

I have been treating this patient for _____ and have made the following referrals:

Printed Name _____

Signature and Date _____

Please stamp this document with your official office stamp or use your letterhead.