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Date:

To Whom It May Concern:

I am the pediatrician for child's name (DOB). Child's name has the following diagnoses:
Cerebral Palsy (ICD code) - Secondary Diagnosis (ICD code)

Third Diagnosis (ICD code) - Fourth Diagnosis (ICD code)

- *Additional Diagnoses added with qualifying ICD codes as required*

I am requesting an alternative seating device for child's name given her complex and severe medical condition. Child's name is nonverbal, has minimal communication and is fed exclusively through a feeding tube and is not mobile due to this severely limiting medical condition. The alternative seating device would be important for ideal head position and control and help with her muscle tone, something not available in any current seating situation. Child's name is at risk for continued deterioration of her anti-gravity muscles, and bone development, as well as skin breakdown due to her immobility. This device would assist with these areas.
This device would also assist child's name with feeding and communication (by way of helping her with swallowing and respiration) which are severely impaired at this time and any help would be of benefit for child's name and her parents.
Given child's name's medical condition, I feel that this alternative seating device would be a huge medical benefit to this child and her family. If there are further questions or inquiries regarding this request, please do not hesitate to contact my office.

Sincerely,

Doctor's signature and printed or typed name

Doctor's title and National Provider Identification Number