Date:

Patient Name:
Patient Date of Birth:

Dear Cleveland Clinic Children's Pediatric Pain Rehabilitation Program,

I am recommending that ______________________________ be admitted to the Pediatric Pain Rehabilitation Program. This patient is diagnosed with the following medical condition(s):

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This patient has demonstrated functional limitations in at least two areas of functioning:

- **Physical mobility:**
- **Independently completing ADLs:**
- **School attendance and academic performance:**
- **Social or recreational activities:**
- **Family interactions:**
- **Emotional functioning:**

This patient has tried these following medications without sufficient pain relief:

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This patient has tried these following therapies without sufficient pain relief:

- **_____ Sessions of physical therapy**
- **_____ Sessions of occupational therapy**
- **_____ Sessions of massage therapy**
- **_____ Sessions of chiropractic therapy**
- **_____ Sessions of psychotherapy**
- **_____ Sessions of biofeedback or neurofeedback**
- **_____ Sessions of electrical stimulation**
- **_____ Sessions of acupuncture or acupressure**
- **_____ Session(s) of ____________________________**
- **Completion of pain management program through _______ without sufficient benefit**

I have currently recommended the following assistive devices to aid in daily functioning:

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- N/A

I recognize this is a focused intensive rehabilitation program targeting increasing functioning for children diagnosed with a chronic pain condition. I will accept the patient back into my care after completion of the program and discharge recommendations.

Thank you for considering this referral.

Sincerely,