



Tennessee Department of Children's Services
Health Services Confirmation and Follow-Up Notification

Youth Information (to be completed by DCS)

Child Name:		DCS Region:	
TFACTS Person ID:		Date of Birth:	
FSW Name:		FSW Phone:	

Healthcare Visit Details (to be completed by Healthcare Provider)

Chief Complaint/Reason for Visit:

Service Provided:

Special Instructions for Caregiver:

Follow-up appointment needed: Yes No Reason: _____
 Is the service today an ongoing service? Yes No If yes, frequency of visits? _____
 Return to clinic (date/time): _____
 Referrals made: _____

Healthcare Provider Details

Clinic Name: _____

Street Address: _____

City, State, Zip: _____

Telephone Number: _____

Date of Service: _____ Would like a contact from DCS? Yes No

Healthcare Provider Name (Print) _____ Date: _____

Healthcare Provider Signature _____

Please send by secure e-mail or fax to DCS within 2 business days: fax:

E-mail:

