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 ID:		Date of Birth:	

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: 423-639-0242; Email: hhuff@fwbfm.com