

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: ☐ Yes ☐ No Follow-up appointment needed: Reason: ☐ Yes ☐ No Is the service today an ongoing service? If yes, frequency of visits? Return to clinic (date/time): Referrals made: **Healthcare Provider Details** Clinic Name Street Address City, State, Zip___ Telephone Number Healthcare Provider Name (Print) _____ Date: Healthcare Provider Signature

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: SAT Coordinator, Child/Youth's Case File, Health Record

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Page 1

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Please send by secure e-mail or fax to DCS within 2 business days: fax: 423-639-0242; Email: hhuff@fwbfm.com