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|  | **Tennessee Department of Children’s Services****Health Services Confirmation and Follow-Up Notification** |

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| --- |
| **Youth Information (to be completed by DCS)** |
| Child Name: | Travis Collins | DCS Region: | Davidson |
| TFACTS Person ID: |       | Date of Birth: | 5/4 |
| FSW Name: | FSW | FSW Phone: |       |

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| **Healthcare Visit Details (to be completed by Healthcare Provider)** |

Chief Complaint/Reason for Visit:

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| --- |
| Travis came to our office today for a dental exam. |
|       |

Service Provided:

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| Travis received a complete exam, x-rays, and cleaning.  |
|       |

Special Instructions for Caregiver:

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| Travis should brush twice a day a floss daily.  |
|       |

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| Follow-up appointment needed: | [x]  Yes [ ]  No | Reason: | one cavity to be filled |
| Is the service today an ongoing service? | [ ]  Yes [x]  No | If yes, frequency of visits? |       |
| Return to clinic (date/time): | two weeks |
| Referrals made: |       |

**Healthcare Provider Details**

|  |  |
| --- | --- |
| Clinic Name: | Smile Dentistry |
| Street Address: |       |
| City, State, Zip: |      |
| Telephone Number: |       |

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| Date of Service: |       | Would like a contact from DCS? [ ]  Yes [x]  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:**