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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: | Michael Collins | DCS Region: | Davidson |
| TFACTS Person ID: |  | Date of Birth: | 6/27 |
| 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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| --- |
| Michael came to our facility today for his initial EPSD&T. |
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Service Provided:

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| Michael received his comprehensive history screening, physical examination, hearing and vision assessments, laboratory testing,and health education. His immunizations are up-to-date. |
|  |

Special Instructions for Caregiver:

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| Michael will also need a dental exam. |
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| --- | --- | --- | --- | --- | --- | --- | --- |
| 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): | | one year | | | | | |
| Referrals made: |  | | | | | | |

**Healthcare Provider Details**

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| --- | --- | --- |
| Clinic Name: | Sylvan Pediatrics | |
| Street Address: |  | |
| City, State, Zip: | HIlton, TN | |
| Telephone Number: | |  |

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| --- | --- | --- |
| 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:**