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

|  |
| --- |
| **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: |       |

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

Chief Complaint/Reason for Visit:

|  |
| --- |
| Michael came to our facility today for his initial EPSD&T.  |
|       |

Service Provided:

|  |
| --- |
| 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:

|  |
| --- |
| Michael will also need a dental exam.  |
|       |

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

**Healthcare Provider Details**

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

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