Tennessee Department of Children's Services

Health Services Confirmation and Follow-Up Notification

Please print all hand written information legibly.

Office Name
Street Address
City, State, Zip
Phone and Fax Number

To be completed by DCS Staff, Resource Parent, or Contract Agency Staff					
Print/Type Name of Child			Social Security Number		Date of Birth
			- -		
was seen by	*(Name of Provider)*				
on	(DOS)	for	*(Reason for Visit)*		
Healthcare Provider Contact Information					
Name					
Street Address					
City		State		Zip Code	
Telephone Number	( ) -				

To be completed by Healthcare Provider						
Results of Visit/Special Instructions for Caregiver						
Follow-Up Appointment Needed	☐ Yes	☐ No	Date /Time of Next Appointment			
Purpose of Follow-Up Visit						
Is service received today an ongoing service?	☐ Yes	☐ No	If yes, what is frequency of service?			
☐ Weekly ☐ Every 2 weeks ☐ Monthly ☐ Other						
Referral for Care Is Needed As Follows						

Healthcare Providers Signature _____ Date _____

Thank you for your time. Please fax this to *(DCS Regional Well Being Office)*