Tennessee Department of Children's Services

Child with Special Health Care Needs

Medical Recommendation and Review

Date of Review: _____ **Type of Review:** ☐ Initial ☐ Quarterly ☐ Other

Reviewer Name: _____ **Reviewer Contact Number:** _____

CHILD'S IDENTIFYING INFORMATION					
Child's Name:		**DOB:**		**Electronic Record System ID:**	
Gender: ☐ Male ☐ Female			**Full Guardianship:** ☐ Yes ☐ No		
Diagnosis:					
Medical Documentation of Diagnosis: ☐ Yes ☐ No **Reported by:**					

DCS CONTACT INFORMATION			
DCS Region:		**Home County:**	
DCS Team Leader:			
DCS FSW Name and Contact Number:			

REVIEW RECOMMENDATIONS

☐ Medical Records from: _____

☐ Interview ☐ Face to Face ☐ Video ☐ Phone

☐ DCS Contract Agency Records

Person: _____ Relationship: _____ Date: _____

☐ **Child has special health care needs that require:**

- ☐ Review by DCS Nurse Consultant in ☐ 3 months ☐ 6 months ☐ Other
- ☐ Specialized training by foster parents/caregivers – completed by current caregivers: ☐ Yes ☐ No
- ☐ Medications – child has all medications required: ☐ Yes ☐ No
- ☐ Durable Medical Equipment – child has all DME required: ☐ Yes ☐ No
- ☐ Medical Supplies – child has all supplies required: ☐ Yes ☐ No
- ☐ Private Duty Nursing – child is receiving PDN hours as authorized: ☐ Yes ☐ No
- ☐ Child required environmental adjustments: ☐ Yes ☐ No

Explain: _____

☐ TN Care Case Manager Name/Contact #: _____

☐ Other: _____

☐ **Child does not currently have special health care needs that require regular review by the DCS Nurse**

Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.

Distribution: Child's Case File, DCS Health Advocacy Nurse, Child Placement Unit, Private Provider

PLACEMENT INFORMATION

☐ Safety Admission: ☐ Yes ☐ No _____

☐ Hospitalization at: _____

Admission Date: _____ Anticipated Discharge Date: _____

Social Worker: _____ Social Worker Contact: _____

Name of Hospital where child typically receives inpatient care: _____

☐ **Foster Home** ☐ **Residential** (if foster home placement) ☐ Kinship ☐ Traditional

Current Placement/Foster Parent Name(s)**:** _____

Contact Number: _____ Current Placement Address: _____

☐ Contract Agency Name: _____

Agency Contact Person and Position: _____

Contact Person Phone Number: _____ Contact Person Email: _____

CURRENT HEALTH CARE PROVIDERS (PCP, Dental, Mental Health and any Specialists)

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Provider Name	Type of Provider	Location	Date of Last Visit	Date and Time of Next Visit

MEDICATIONS

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Does child have a 3-day supply of all medications? ☐ Yes ☐ No

Pharmacy and contact number	

Medication	Dose	Frequency	Prescriber

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Reported by: _____

Comments:

☐ **NO KNOWN ALLERGIES**

List Any Known Allergy	Reaction	EPI Pen
		☐ Yes ☐ No, needs eval ☐ No not needed
		☐ Yes ☐ No, needs eval ☐ No not needed
		☐ Yes ☐ No, needs eval ☐ No not needed
		☐ Yes ☐ No, needs eval ☐ No not needed

THERAPY

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Does child receive any therapy services such as PT, OT, Speech, and Behavioral Therapy, etc.? ☐ Yes ☐ No

☐ Physical Therapy

Provider			Frequency	Location
☐ Home	☐ Outpatient	☐ School	If Outpatient, list location:	

☐ Occupational Therapy

Provider			Frequency	Location
☐ Home	☐ Outpatient	☐ School	If Outpatient, list location:	

☐ Speech Therapy

Provider			Frequency	Location
☐ Home	☐ Outpatient	☐ School	If Outpatient, list location:	

☐ Other Therapy

Provider			Frequency	Location
☐ Home	☐ Outpatient	☐ School	If Outpatient, list location:	

SPECIAL MEDICAL EQUIPMENT (Durable Medical Equipment)

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Does child have any special medical equipment or DME (Durable Medical Equipment) and Supplies? ☐ Yes ☐ No

- ☐ Wheelchair
- ☐ Brace(s)
- ☐ Other walking aids/mobility devices
- ☐ Suction machine/equipment
- ☐ Vent/Trach supplies
- ☐ Oxygen
- ☐ Pulse Oximeter
- ☐ Nebulizer
- ☐ CP Vest
- ☐ Cough assist
- ☐ Other respiratory equipment
- ☐ Feeding pump
- ☐ Diapers
- ☐ Lift
- ☐ Helmet
- ☐ Ostomy supplies
- ☐ Cath supplies
- ☐ Other adaptive equipment
- ☐ Communication device (like communication boards)
- ☐ Hearing aid/Cochlear implant
- ☐ Specialized seating system
- ☐ Car seat
- ☐ Diabetic supplies (meter, needles, syringes)
- ☐ Hospital/Safety bed
- ☐ Special bath equipment
- ☐ Other _____

DME Provider(s) and Contact Information:

PRIVATE DUTY NURSING

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Does child have home health services prescribed or provided? ☐ Yes ☐ No

Provider:

☐ Skilled Hours Approved: _____

☐ Unskilled Hours Approved: _____

Notes/Comments:

DIET/NUTRITION

☐ **LITTLE OR NO INFORMATION AVAILABLE**

CURRENT DIET:

- ☐ Regular Diet
- ☐ Special Diet
- ☐ Food Allergy
- ☐ Nothing by Mouth
- ☐ Thickener Needed
- ☐ Special Feeding Utensils
- ☐ G Tube Feedings
- ☐ Child able to have pleasure feeds

Notes/Comments:

ACTIVITIES OF DAILY LIVING/SPEECH/VISION/HEARING

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Is child (over the age of 5 years) able to complete their own ADLS? ☐ Yes ☐ No

Child Needs Assistance with:

- ☐ Bathing
- ☐ Dressing
- ☐ Feeding
- ☐ Toileting
- ☐ Bowel or Bladder Issues
- ☐ Diapers
- ☐ TOTAL CARE – Complete care for bathe, bowel, bladder, mobility

Speech/Vision/Hearing:

- ☐ Verbal: ☐ Limited Verbal ☐ Non Verbal ☐ Sign Language
- ☐ Hearing Impaired
- ☐ Deaf: ☐ Right ☐ Left ☐ Both
- ☐ Visually Impaired: ☐ Glasses ☐ Contacts
- ☐ Blind: ☐ Right ☐ Left ☐ Both

Notes/Comments:

MOBILITY ISSUES

☐ **LITTLE OR NO INFORMATION AVAILABLE**

Does this child have mobility issues? ☐ Yes ☐ No ☐ Partial ☐ Total

- ☐ Requires assistive device for:
- ☐ Non ambulatory has wheel chair: ☐ Manual ☐ Electric ☐ Operated by Child ☐ Needs Assistance
- ☐ Paraplegic
- ☐ Hemiplegic ☐ Right ☐ Left
- ☐ Needs Equipment Consultation
- ☐ Child Requires Special Transport
- ☐ Child Requires Special Car Seat
- ☐ Child Has Lift

Notes/Comments:

MEDICAL NEEDS AT SCHOOL

☐ **LITTLE OR NO INFORMATION AVAILABLE**

☐ Current School: _____

☐ Home School: _____

Does the child need nursing services or accommodations at school? ☐ Yes ☐ No

Always check the "Forms" Website for most current version and disregard all previous versions. This form may not be altered.

Does the child have a 504 plan? ☐ Yes ☐ No
Does the child have an IEP? ☐ Yes ☐ No

Notes/Comments:

Does this child have medical equipment or medications at school? ☐ Yes ☐ No
Consultation needed with DCS Educational Specialist? ☐ Yes ☐ No
What kind of staffing is required at school? ☐ Yes ☐ No

Notes/Comments:

TRAINING

Will caregivers be required to have any training or instruction from Hospital or provider for equipment, medication, or medical condition(s)? ☐ Yes ☐ No

☐ All medical equipment as noted above
☐ Medical Conditions/Diagnosis: _____
☐ Diabetes: _____
☐
Medications: _____
☐ Medical Procedures: _____
☐ Other:
☐ Caregivers have completed all currently required training to meet medical needs of this child:
☐ Yes ☐ No
☐ Caregivers need training completed for: _____

Notes/Comments:

_____ _____
Nurse Reviewer Signature **Date**

Department of Children's Services
INSTRUCTIONS FOR USE OF FORM
CS-0716
Child with Special Health Care Needs

PURPOSE: To provide information about any child with significant medical needs that will assist with placement determination, ensure continuity of medical care and determine possible additional medical needs when entering into DCS custody.

When a child with complex medical needs enters custody, the DCS Health Nurse completes this form based on the medical knowledge obtained from hospital records, medical providers, and/or parents/guardians for the child.

When the DCS Health Nurse determines whether or not the child meets the criteria for a Child with Special Health Care Needs, that recommendation is documented on page 1 of the form. The completed form is signed, dated and uploaded into the Electronic Record System documents.

When the DCS Health Nurse conducts a scheduled review of the Child with Special Health Care Needs that review, and any updates or changes are noted on the form and the review recommendations are documented on page 1 of the form. The completed form is signed, dated and uploaded into the Electronic Record System documents.