

# RECOMMENDATIONS FOR CONTINUED SERVICES

**Name of Inpatient Facility**

Identifying Information																			
Patient							SSN												
Address																			
Admission Date				Sex			Age			Date of Birth			Race						
Name of Parent/ Guardian/Caretaker									Home Phone				Cell Phone						
Custody				Non-Custody				County of Charges				Hearing Date							
Insurance Information																			
Enrolled in TennCare	Yes			End Date			No			Pending			Commercial Insurance	Yes			No		
Name of Insurance/ BHO Contact Person & Phone																			
Name of DCS/CSA TennCare Representative & Phone																			
Legal/Charges																			
Charges and Date of Charges																			
Sex offense charge	Y			N			If Yes, List sex offense charge												
Psychosexual Requested	Y			N			Psychosexual Completed		Yes			No			Pending				
RECOMMENDATIONS																			
RTF	Y			N			If Yes, Indicate Type		A&D			Sex Offender			Other				
COMMENTS TO SUPPORT CLINICAL RECOMMENDATIONS																			
Participants																			
Name of Requesting Clinician										Date									
Facility Services Coordinator/Contact Person										Telephone Number									
Recorded by										Date									

cc: BHO/DCS