Office of Maternal, Child and Family Health
Right From The Start Program
Correction Request Form

Date _____ Agency/Region _____

Clerk _____ DCC Name _____

Dear DCC,

The following information is required to complete this chart according to RFTS protocol. **Return a copy of this request along with the corrected forms to the Regional Lead Agency within five working days**. A copy of the correction is to be maintained in the client's chart at your DCC Agency.

Client Name _____ Prenatal Infant

☐ Case closure past due ☐ Correct highlighted areas on attached forms Areas with asterisk are mandatory

	Form #	*Form Name*	*Service Date(s)*	*Correction Needed*
	R001A	**Client Tracking**		
	R004	**Rights & Responsibilities/ Caregiver Permission**		
	R011A	**Service Care Plan**		
	R013	**External Referral form**		
	R015	**Progress Notes**		
	R019	**Referral Form**		
	R022	**Outcome Measures**		
	R036	**Initial Assessment**		
	R039	**Provider Closure Letter**		
	R060	**Enhanced Services Only**		
	R065	**Edinburgh**		
	TS001	**SCRIPT Form**		
		Relationship Assessment Tool		
		SBIRT form		
	AUDIT	**Alcohol Use Disorders Identification test form**		
	DAST-10	**Drug Abuse Screen test (DAST) form**		
		ASQ SE at 6 months		
		ASQ-3 at 9 months		
		ASQ-3 at 12 months		

Other: _____

I have made the above requested corrections and placed a corrected copy in the client's chart.

DCC Signature: _____ Date: _____