HEALTH TRACKS APPOINTMENT SLIP

ND Department of Human Services
SFN 705 (02-2006)

Screenee's Name:
Appointment Date and Time:

Provider's Name:		Telephone Number:	
Street Address:	City:	State:	Zip:
Comments:			

IMPORTANT:	If you are unable to keep this appointment please call ________________________.

County Worker's Name:	County:	Telephone Number:

REMEMBER: If you need help with transportation, please call your local county service office.

DISTRIBUTION: Original Copy - Parent
Canary Copy - File

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