UAMS PACE INTAKE FORM

Please complete fields below and send form via SHAREmail to UAMSPACE PedsIntake:

CHILD'S NAME: **CLIENT ID:**

REMOVAL DATE:

Current placement name and address (including city, county and zip):

Placement name:
Placement city:
Placement county:

Health Service Worker with contact phone number:

@arkansas.gov
HSW Zipcode:

HSW Phone: (

Sex: DOB: DCFS Area Number:

****

********** **IF CHILD IS OUT OF CUSTODY AT TIME OF REFERRAL, DO NOT COMPLETE FIELDS 1 – 17** **********

****

1. CHILD'S NAME:
2. SOCIAL SECURITY #:
3. FSW:
4. FSW PHONE:
5. CHRIS #:
6. Number of Previous Removals:
7. Number of patient's siblings in foster care custody:
8. RACE:
9. ETHNICITY:
10. PRIMARY LANGUAGE:
11. INTERPRETER REQUIRED:
12. MOTHER'S NAME:
13. PATIENT AKA ALIAS:
14. DHS REMOVAL COUNTY:
15. CHRIS Removal Condition(s): Include reason for foster care placement
16. DATE INTAKE SUBMITTED:
17. Additional comments/requests:

Use tab or mouse to move from field to field and enter data

***** CURRENT VERSION *****

UAMS PACE RECORD LIST

CHILD'S NAME: **DOB:**

Please put the name and mailing address of providers in the blank or write NA if not applicable:

Primary Care Physician:
Birth Hospital (required for infants 18 months or younger):
Medical Specialist(s):
Mental Health Provider-Inpatient:
Mental Health Provider-Outpatient:
School-Current:
Developmental Preschool/Therapies:
Dentist:
Eye Doctor (Optometrist/Ophthalmologist):

Other:

UAMS: Project for Adolescent and Child Evaluations (PACE) Questionnaire
Please answer the following questions and *bring or send to the appointment*

Completed by: (Name/Title/Contact Number)_____ Date: _____

Child's name:_____ Where is the child living?_____

How many siblings and where are they placed? _____

_____

What school/developmental preschool/daycare does the child **currently** attend and Grade level?

What school/developmental preschool/daycare did the child **previously** attend and Grade level?

Does the child receive special education services, speech-language therapy, occupational therapy or physical therapy (circle)? Describe: _____

Does the child have any problems with learning or with behavior at school? _____ Describe: _____

_____

What family members does the child visit? Indicate if supervised: _____

_____

Child's response to visits: _____

_____

Does the child receive mental health therapy, and if so where? _____

Has the child been to the dentist? ____ When and where? _____

Has the child been to the eye doctor? ____ When and where?_____

Any concerns regarding hearing or vision? _____

Did the child pass newborn hearing screening? ____ If no, what has been follow-up? _____

Where was the child born (Town and Hospital)?_____

Who is the PCP (Name and Town)? _____

Current Medical concerns?_____

_____

What medications is the child taking and why?_____

_____

Sleeping or nighttime behavioral concerns (i.e., bedwetting, night terrors, delayed sleep onset, etc.):

_____

Does the child/teen have any diet/eating concerns? ____ Describe:_____

_____

Babies: What formula are they eating and how much a day? _____

_____

Babies/toddlers: Do they eat (circle) baby foods, table foods? List what kinds: _____

_____

Any concerns about feeding (choking, coughing, spitting up)? _____

_____

Any family history of medical problems, legal history or mental illness? _____

_____

Additional concerns or information:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDREN AND FAMILY SERVICES
CFS-352: MEDICAL, DENTAL, VISION, HEARING, AND PSYCHOLOGICAL EPISODIC FORM

(To be completed EACH visit)

CHILD'S NAME: _____ **DATE OF BIRTH:** _____ **MEDICAID #:** _____

DATE OF EXAM: _____ **TIME OF EXAM:** _____ **(AM / PM) DCFS CASE #:** _____

TYPE OF VISIT: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ HEARING ☐ HOSPITAL
☐ PSYCHOLOGICAL (COUNSELING SESSIONS AT SCHOOL ALSO)

PROBLEM/DX: (Resource Parent or FSW please write why child is being seen) (Provider please write diagnosis)

TREATMENT: (Provider please write all medications given and all treatments ordered)

DENTAL TOOTH SURFACE:

FOLLOW-UP NEEDED: (Please state date of follow up also referrals)

ACCOMPANIED BY: ☐ Resource Parent ☐ Family Service Worker ☐ Volunteer ☐ Other (Specify**)** _____

Provider Signature/Title: _____ **Provider Address: (Office Stamp or print)**

Print Name: _____

Phone #: _____

MAIL TO THE HEALTH SERVICE WORKER AS SOON AS THE APPOINTMENT IS COMPLETED.
Keep a copy for your records and to turn in with Medicaid travel.

Arkansas Department Of Health & Human Services
Division of Children & Family Services
Requested Medical Records Log

Name of Child: _____ Date Entered Care: _____

Past Medical History Records Requested

Name & Address of Provider From Whom Records Requested	Records Requested	Date Requested	Initials *	Date Received	Initials *
	Newborn				
	Pediatric				
	Immunization				
	Hospitalization				
	Dental				
	Psychological				
	Speech/Hearing/Eye				
	Pharmacy				
	Developmental Delays				
	Family Medical History				
	Previous Caretakers				
	School (Medical)				

Current Medical Treatment Records Requested

Name & Address of Provider From Whom Records Requested	Records Requested	Date Requested	Initials *	Date Received	Initials *

*** Identify name and title after documenting information on log**

_____ _____ _____ _____

_____ _____ _____ _____

Arkansas Department of Human Services
Division of Children and Family Services
Medi-Alert to Resource Provider

I. CHILD'S INFORMATION

Name **SSN** **DOB** **Sex** **Case #**

Primary Language **Information regarding child below provided by:** ☐ Mother ☐ Father ☐ Other

Child Receives SSI Benefits? Yes ☐ No ☐ TBD ☐ **Child Receives SSA Benefits?** Yes ☐ No ☐ TBD ☐

FSW **FSW Phone** **FSW Email** **Date**

II. CHILD'S CURRENT CARETAKER AND HEALTH CARE PROVIDER INFORMATION

Caretaker Name PCP Name PCP Address PCP Phone

III. CHILD'S PLACEMENT INFORMATION

Placement Date or Move Placement Type Health Report Attached? Yes ☐ No ☐ Child Not Examined ☐

IV. CHRONIC HEALTH PROBLEMS

- ☐ Anemia
- ☐ Asthma/Wheezing
- ☐ Bone/Joint Problems
- ☐ Constipation
- ☐ Delayed Development
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Ear Infection
- ☐ Eczema/Rashes
- ☐ Epilepsy/Seizures
- ☐ Hearing Problems
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irregular/Painful Menses
- ☐ Kidney Problems
- ☐ Lung Disease
- ☐ Sickle Cell Anemia
- ☐ Speech Issues
- ☐ Sore Throat
- ☐ Tooth Decay
- ☐ Urinary Tract Infection
- ☐ Vaginal Discharge
- ☐ Vision Problems
- ☐ Other

V. MENTAL/BEHAVIORAL HEALTH

- ☐ Bedwetting
- ☐ Depression
- ☐ Disruptive/Violent
- ☐ Fire Setting
- ☐ Head Banging
- ☐ Hyperactive/ADD/ADHD
- ☐ Suicide Attempts
- ☐ Other

VI. ALLERGIES

- ☐ Chemicals
- ☐ Food
- ☐ Insect Bites
- ☐ Medications
- ☐ Other

VII. SPECIAL NEEDS

- ☐ Apnea Monitor
- ☐ Contacts/Glasses (circle as applicable)
- ☐ Crutches
- ☐ Hearing Aid (circle: right/left/both)
- ☐ Orthopedic Appliance
- ☐ Special Diet
- ☐ Wheelchair
- ☐ Other

VIII. PERSONAL HYGIENE

- ☐ Bathes Self
- ☐ Dresses Self
- ☐ Fixes Hair
- ☐ Needs Assistance w/ Daily Activities

IX. FEARS/PHOBIAS

- ☐ Animals
- ☐ Darkness
- ☐ Loud Noises
- ☐ Other

X. HABITS

- ☐ Cigarettes ☐ Other
- ☐ Alcohol Use
- ☐ Illegal Drug Use
- ☐ Sexually Active

XI. EDUCATION

School_____ **Grade**_____ **Teacher Name**_____

Class Type: ☐ Regular ☐ Special Education ☐ Has been homeschooled ☐ Not in school ☐ Refuses to go to school ☐ IEP?

XII. IMMUNIZATIONS

Was child's immunization record given to resource provider? ☐ Yes ☐ No ☐ None Available

XIII. HOSPITALIZATIONS/SURGERIES (description and dates):_____

XIV. PRESENT MEDICATIONS

Name	Purpose	Dose/Frequency	Start Date	Stop Date	Prescribing Physician Name

XV. COMMENTS

XVI. SIGNATURES

I received a copy of the CFS-362 at placement.

_____

Resource Provider Signature Date

I provided a copy of the CFS-362 at placement.

_____

Family Service Worker Signature Date

Arkansas Department of Human Services
Division of Children and Family Services

RECEIPT OF MEDICAL PASSPORT FOR A CHILD IN FOSTER CARE AND ACKNOWLEDGEMENT OF CONFIDENTIAL NATURE OF INFORMATION CONTAINED IN THE MEDICAL PASSPORT

I have received the Medical Passport for _____, a child placed in my care.

I understand that all Medical Passport information is confidential. I may share it only with health care providers and Department of Human Services (DHS) staff. If I have any questions, I will contact the child's foster care worker.

I will return the Medical Passport to the DHS, Division of Children and Family Services when the child named above is no longer placed in my home or other placement agency.

_____ _____
Resource Parent or Placement Provider Representative Signature Date

_____ _____
Resource Parent or Placement Provider Representative Name (print/type) Placement Facility Name, if applicable

VERIFICATION OF MEDI-ALERT CFS-362

(If a new Medi-Alert [CFS-362] is not completed, the worker must complete this section.)

I verify that the information on the existing Medi-Alert (CFS-362) dated _____ is current and complete on the date of this placement.

_____ _____
Worker's Signature Date

RETURN OF MEDICAL PASSPORT FROM RESOURCE PROVIDER

The above-named child has been removed from the placement provider's care and the Medical Passport has been returned.

_____ _____
Worker's Signature Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDREN & FAMILY SERVICES
HEALTH SCREENING PART 1

(To be completed by Health Care Provider)

NAME	DATE OF BIRTH	CASE NUMBER	DATE OF EXAM	TIME

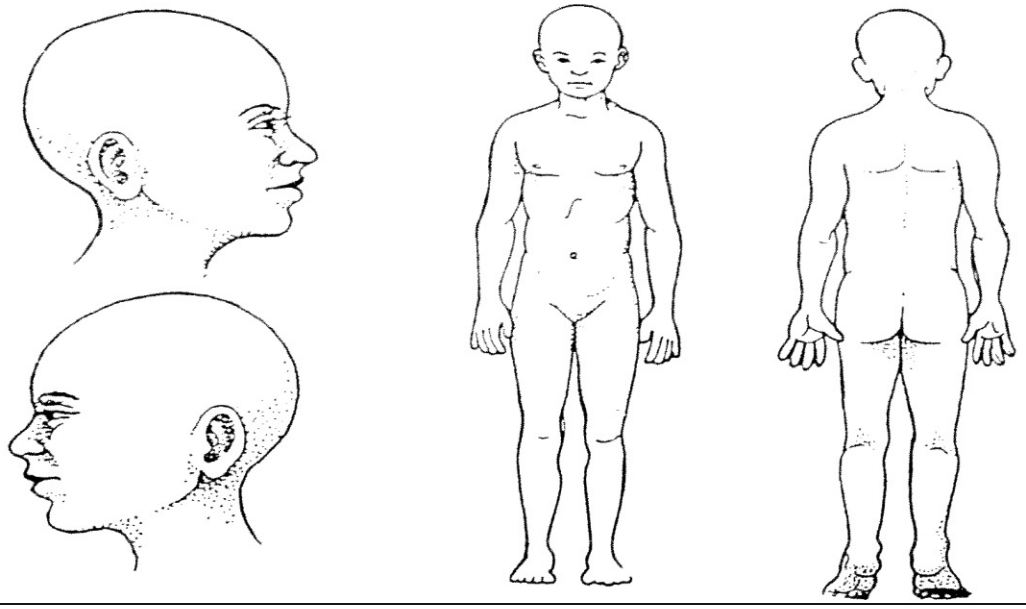
BRIEF HISTORY PROVIDED TO FAMILY SERVICE WORKER BY PARENT

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	COMMENTS/DESCRIPTION OF ABNORMALITIES
HEIGHT	IN.	IN.	
WEIGHT	LB.	LB.	
HEAD CIRC.	CM.	CM.	
BP	/	/	
NUTRITIONAL STATUS			
HEAD			
EYES			
EARS			
NOSE			
THROAT/MOUTH			
NECK			
CHEST			
HEART			
ABDOMEN			
GENITALIA/PELVIC			
ANUS			
EXTREMITIES			
LYMPHATICS			
NEUROLOGIC			
SKIN			
DEVELOPMENT			
Cognitive			
Personal-Social			
Speech-Language			
Motor			
Gross, Upper Body			
Gross, Lower Body			
Gross, Overall			
Fine			
Visual			
HEARING			
VISION	/	/	
DENTAL			
❖ APPEARS TO BE HALLUCINATING OR DELUSIONAL			
❖ EXPRESSES SUICIDAL IDEAS OR WISHES			
❖ EXPRESSESWISH TO HARM OTHERS			
❖ COMBATIVE OR VIOLENT			

❖ Responses can be checked by the Family Service Worker, Health Specialist, Health Services Worker or the foster care provider. If "yes" checked, the Family Service Worker will make a referral to the local Mental Health Center. These children will be seen immediately by a licensed clinical psychologist or a licensed psychiatrist, if available. Experience in child psychiatry is preferred.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILDREN & FAMILY SERVICES
HEALTH SCREENING PART 2
(To be completed by Health Care Provider)

Document the abnormal cutaneous findings on figures below and in "comments" section on page 1.



IMMUNIZATIONS: Up to date: ☐ Yes ☐ No TB Test: ☐ Positive ☐ Negative
CURRENT RX: Name/Strength/Dose/Frequency ☐ Not Indicated

LAB (as indicated by periodicity schedule or history): ☐ Blood Lead ☐ Pap Smear
Hemoglobin/Hematocrit: _____ ☐ Cholesterol ☐ GC Culture
Urinalysis: _____ ☐ Other: (list) _____

LAB (tests performed; results if available)
Blood: _____ WET PREP: _____
TB TEST: ☐ Done ☐ Not Done WASHINGS: _____
CULTURES: _____ OTHER: _____

X-RAYS _____

ASSESSMENT/ DX _____

RECOMMENDATIONS/ TREATMENT/ RX _____

Done at: ☐ AHD (EPSDT) ☐ Hospital ☐ Private Clinic ☐ AHEC
Signed by: ☐ RN ☐ MD ☐ PA ☐ RNP

Accompanied By: ☐ Foster Care Provider ☐ Family Service Worker
☐ Health Services Worker ☐ Other

Name of Medical Provider (print) _____

Address _____ City _____ State _____

Signature of Medical Provider _____ **Phone** _____

CFS-366-B (12/2014) 10008534

White- Medical Passport Yellow- Child's Case Record Pink- Health Specialist/ Health Services Worker

Arkansas Department of Human Services
Division of Children & Family Services

Child's Health Services Plan

Date of Initial Plan

Name: DOB: Case: Allergies: Chronic Illnesses:

Date	Problem/Need	Recommended Treatment/Follow-up (include dates)	Medications	Provider	Problem Status/Treatment Outcome (include date if applicable)

Date	Problem/Need	Recommended Treatment/Follow-up (include dates)	Medications	Provider	Problem Status/Treatment Outcome (include date if applicable)

I certify that the above plan, as completed or revised, is appropriate for this child:

_____
Reviewed/Approved by Health Specialist or Area Director Designee (Signature/Title) DATE

_____
Reviewed/Approved by Health Specialist or Area Director Designee (Signature/Title) DATE

_____
Reviewed/Approved by Health Specialist or Area Director Designee (Signature/Title) DATE

_____
Reviewed/Approved by Health Specialist or Area Director Designee (Signature/Title) DATE