

# 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:

@dhs.arkansas.gov

**HSW Zipcode:**

**HSW Phone: (**

**Sex:**

**DOB:**

**DCFS Area Number:**

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\*\*\*\*\* **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. CASE #:
  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. 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: (Please list past and present, if known)
Birth Hospital (required for infants 18 months or younger):
Medical Specialist(s):
Mental Health Provider-Inpatient:
Mental Health Provider-Outpatient:
School-Current: (Please list past and present, if known)
Developmental Preschool/Therapies: (Please list past and present, if known)
Dentist:
Eye Doctor (Optometrist/Ophthalmologist):

Other: ACH/ Vital Records