



**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 – Also School Based Counseling)

NAME OF CHILD: _____ **DATE OF BIRTH:** _____ **DCFS CASE #:** _____
(Foster Parent writes child's name, Birth Date, and Case # before going to the provider)

DATE OF EXAM: _____ **TYPE OF VISIT:** MEDICAL DENTAL VISION HEARING HOSPITAL
(Foster Parent writes date in) PSYCHOLOGICAL (COUNSELING SESSIONS AT SCHOOL ALSO)

PROBLEM/DX: (Foster 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: Foster Care Provider Family Service Worker Other (Specify) _____

Provider Signature/Title: _____
Print Name: _____
Phone #: _____

Provider Address: (Office Stamp or print)

MAIL TO THE HEALTH SERVICE WORKER AS SOON AS THE APPOINTMENT IS COMPLETED.