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.