Unscheduled Hospitalization Form

Individual Name:
Date of Hospitalization:

Date Form Filled Out:
MUI Number:

Name of Person filling out Form:
Title:
Contact Information:

Agency:

HISTORY/ANTECEDENTS:
Please list what led to the hospitalization and the medical history of the individual. Have there been recent similar illnesses? What was the health of the individual in the 72 hours leading up to the hospitalization?

TYPE OF HOSPITALIZATION:
☐ Medical ☐ Psychiatric
Was the individual treated at the emergency room?

If so, what was the treatment?

How many days was the individual in the hospital?

REASON FOR HOSPITALIZATION – Please mark all that apply:

- ☐ Abdominal Pain
- ☐ Abnormal Blood Levels
- ☐ Absent Pulse
- ☐ Allergic Reaction
- ☐ Altered State
- ☐ Baclofen Pump Issues
- ☐ Blood Clots
- ☐ Blood Pressure
- ☐ Blood Sugar Levels
- ☐ Body Temperature Variations
- ☐ Bowel Obstruction
- ☐ Cancer
- ☐ Chest Pains
- ☐ Decubitus Ulcer
- ☐ Dehydration/Volume Depletion
- ☐ Edema
- ☐ Emesis (Vomit, Diarrhea)
- ☐ Gallbladder
- ☐ Heart Problems
- ☐ Impaired Respiration
- ☐ Infection
- ☐ Ingestion-PICA
- ☐ Kidney
- ☐ Medical Error
- ☐ Observation/Evaluation
- ☐ Placed item in Orifice
- ☐ Pneumonia & Influenza

Other:

SYMPTOMS AND RESPONSE:
What were the individual's symptoms – over what length of time – and what was the response?

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DIAGNOSIS AND DISCHARGE SUMMARY:
Please describe in detail the individual's diagnosis and discharge summary.

FOLLOW-UP APPOINTMENTS/CHANGES TO MEDICATIONS/CONTINUING:
Please list the changes and the continuing needs of the individual along with the person responsible for these. Please attach discharge paperwork and follow-up appointment outcomes.

CAUSE AND CONTRIBUTING FACTORS:

- ☐ **Medication Change**
- ☐ **Choked on Food**
- ☐ **Medication Error**
- ☐ **Fall-Due to Environmental Factors**
- ☐ **Fall-Due to Mobility Issues**
- ☐ **Aspiration due to Improper Diet Texture**
- ☐ **Failure to provide timely medical care**
- ☐ **Staff did not monitor input/output of fluids**

Other:

PREVENTION MEASURES:

- ☐ **Physical/Social Environmental Change**
- ☐ **Agency Policy/System Change**
- ☐ **Staff Training**
- ☐ **Counseling**
- ☐ **Team Meeting to address ISP Change**
- ☐ **Appointment with Medical Care Provider**
- ☐ **Medication Change**
- ☐ **Follow up Appointment Scheduled**
- ☐ **PT/OT/Speech Referral made to address communication or mobility concern**
- ☐ **Diet Change Ordered**
- ☐ **Home Health Care**

Other:

INVESTIGATIVE AGENT REVIEW:

Comments & Questions:

REVIEW COMPLETED DATE: **IA NAME:**