**Unscheduled Hospitalization Form**

**Please complete this form and send electronically (via email when possible) to the County Board as directed.**

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| **NAME OF INDIVIDUAL/MUI#:** |
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| **NAME AND TITLE OF PERSON COMPLETING FORM:** |
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| **CONTACT INFORMATION OF REPORTER/AGENCY:** |
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| **DATE AND TIME OF HOSPITALIZATION:** |
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| **NUMBER OF DAYS IN HOSPITAL:**  **Consider the day of admission as first day and the day of release as the last day** |
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| **TYPE OF HOSPITALIZATION (MEDICAL OR PSYCHIATRIC)** |
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| **NAME OF HOSPITAL** |
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| **REASON(S) FOR HOSPITALIZATION:**  **Please include symptoms, issues and/or concerns that lead to hospitalization; description of incident; if symptoms were addressed in a timely manner and if not why** |
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| **DESCRIPTION OF INDIVIDUAL’S HEALTH FOR 72 HOURS PRIOR TO HOSPITALIZATION:** |
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| **HAS THE INDIVIDUAL EXPIERENCED ANY RECENT SIMILAR ILLNESSES? If so, please explain** |
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| **PROVIDE DATE AND CAUSE OF MOST RECENT HOSPITALIZATION BEFORE THIS ONE?** |
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| **INDIVIDUAL’S DIAGNOSIS AND MEDICAL HISTORY FROM THE ISP:** |
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| **HOSPITAL DIAGNOSIS:**  **\*ATTACH HOSPITAL DISCHARGE PAPERWORK** |
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| **WAS HOSPITALIZATION DUE TO FLU OR PNEUMONIA OR ASPIRATION PNEUMOMIA?**  **If yes, did the individual receive the flu shot or pneumonia vaccine?** |
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| **PREVENTION PLAN:**   * **Please include any changes** * **Follow up appointments** * **Continuing needs of the individual** * **Person responsible for each** |
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| **NOTES:** |
| Unscheduled Hospitalization Form 3-9-14 |