Unanticipated Hospitalization MUI Form

Individual's Name: **Date Form Completed:**

Date of Hospitalization: **MUI Number:**

Name of Person Completing Form:

Title: **Provider:**

Contact Information:

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**

How many days was the individual in the hospital?

REASON FOR HOSPITALIZATION – Please mark all that apply:

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

Other:

SYMPTOMS AND RESPONSE:

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

DIAGNOSIS AND DISCHARGE SUMMARY:

Please describe in detail the individual's diagnosis and discharge summary. Please attach discharge summary.

FOLLOW-UP APPOINTMENTS / CHANGES TO MEDICATIONS / CONTINUING CARE

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 Changes ☐ Appointment with Medical Care Provider	☐ Medication Changes ☐ 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:**