**Unscheduled Hospitalization Form**

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

|  |
| --- |
| **NAME OF INDIVIDUAL/MUI#:** |
|       |
| **NAME AND TITLE OF PERSON COMPLETING FORM:**  |
|       |
| **CONTACT INFORMATION OF REPORTER/AGENCY:** |
|       |
| **DATE AND TIME OF HOSPITALIZATION:** |
|       |
| **NUMBER OF DAYS IN HOSPITAL:****Consider the day of admission as first day and the day of release as the last day** |
|       |
| **TYPE OF HOSPITALIZATION (MEDICAL OR PSYCHIATRIC)** |
|       |
| **NAME OF HOSPITAL** |
|       |
| **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** |
|       |
| **DESCRIPTION OF INDIVIDUAL’S HEALTH FOR 72 HOURS PRIOR TO HOSPITALIZATION:** |
|       |
| **HAS THE INDIVIDUAL EXPIERENCED ANY RECENT SIMILAR ILLNESSES? If so, please explain** |
|       |
| **PROVIDE DATE AND CAUSE OF MOST RECENT HOSPITALIZATION BEFORE THIS ONE?** |
|       |
| **INDIVIDUAL’S DIAGNOSIS AND MEDICAL HISTORY FROM THE ISP:** |
|       |
| **HOSPITAL DIAGNOSIS:****\*ATTACH HOSPITAL DISCHARGE PAPERWORK**  |
|       |
| **WAS HOSPITALIZATION DUE TO FLU OR PNEUMONIA OR ASPIRATION PNEUMOMIA?** **If yes, did the individual receive the flu shot or pneumonia vaccine?** |
|       |
| **PREVENTION PLAN:*** **Please include any changes**
* **Follow up appointments**
* **Continuing needs of the individual**
* **Person responsible for each**
 |
|       |
| **NOTES:** |
|       |