

# 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:

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

- |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medication Change<br><input type="checkbox"/> Choked on Food<br><input type="checkbox"/> Medication Error<br><input type="checkbox"/> Fall-Due to Environmental Factors<br><input type="checkbox"/> Fall-Due to Mobility Issues | <input type="checkbox"/> Aspiration due to Improper Diet Texture<br><input type="checkbox"/> Failure to provide timely medical care<br><input type="checkbox"/> Staff did not monitor input/output of fluids |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Other:**

**PREVENTION MEASURES:**

- |                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Physical/Social Environmental Change<br><input type="checkbox"/> Agency Policy/System Change<br><input type="checkbox"/> Staff Training<br><input type="checkbox"/> Counseling<br><input type="checkbox"/> Team Meeting to address ISP Changes<br><input type="checkbox"/> Appointment with Medical Care Provider | <input type="checkbox"/> Medication Changes<br><input type="checkbox"/> Follow up Appointment Scheduled<br><input type="checkbox"/> PT/OT/Speech Referral made to address communication or mobility concern<br><input type="checkbox"/> Diet Change Ordered<br><input type="checkbox"/> Home Health Care |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Other:**

**INVESTIGATIVE AGENT REVIEW:**

Comments & Questions:

**REVIEW COMPLETED DATE:**

**IA NAME:**