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:

Unscheduled Hospitalization Form 3-9-14