Unanticipated Hospitalization MUI Form

- Individual's Name:	Data F	arma Camandatadi	
		orm Completed:	
Date of Hospitalization:	MUI Nu	imber:	
Name of Person Completing Form:			
Title:	Provide	er:	
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 □ Abnormal Blood Levels □ Absent Pulse □ Allergic Reaction □ Altered State □ Baclofen Pump Issues □ Blood Clots □ Blood Pressure □ Blood Sugar Levels □ Body Temperature Variations □ Bowel Obstruction 	 □ Cancer □ Chest Pains □ Decubitus Ulcer □ Dehydration/Volume □ Depletion □ Edema □ Emesis (Vomit, Diality Gallbladder □ Gallbladder □ Generalized Pain □ Heart Problems □ Impaired Respiration 	□ Placed item in Orifice □ Pneumonia and Influenza □ Seizures □ Shunt □ Stroke □ Syncope	
Other:			
SYMPTOMS AND RESPONSE:			
What were the individual's symptoms – ov	ver 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:		