



Unanticipated Hospitalization MUI Form

Individual's Name: _____ Date Form Completed: _____
Date of Hospitalization: _____ MUI Number: _____
Name of Person Completing Form: _____ Provider: _____
Title: _____
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

Pressure

Blood Sugar Levels

Body Temperature Variations

Bowel Obstruction

Cancer

Chest Pains

Decubitus Ulcer

Dehydration/Volume Depletion

Edema

Emesis (vomiting/diarrhea)

Gallbladder

Generalized Pain

Heart Problems

Impaired Respiration

Infection

Ingestion- PICA

Kidney

Medical Error

Observation/Evaluation

Placed item in Orifice

Pneumonia and Influenza

Seizures

Shunt

Stroke

Syncope 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:

IA NAME: _____ **Review Completed Date:** _____