Ohio | Department of Developmental Disabilities

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:

☐ Abdominal Pains	☐ Cancer	☐ Ingestion- PICA
☐ Abnormal Blood Levels	☐ Chest Pains	☐ Kidney
☐ Absent Pulse	☐ Debucitus Ulcer	☐ Medical Error
☐ Allergic Reaction	☐ Dehydration/Volume Depletion	☐ Observation/Evaluation
☐ Altered State	☐ Edema	☐ Placed item in Orifice
☐ Baclofen Pump Issues Blood	☐ Emesis (vomiting/diarrhea)	☐ Pneumonia and Influenza
☐ Pressure	☐ Gallbladder	☐ Seizures
☐ Blood Sugar Levels	☐ Generalized Pain	☐ Shunt
☐ Body Temperature Variations	☐ Heart Problems	☐ Stroke
☐ Bowel Obstruction	☐ Impaired Respiration	☐ Syncope Uncontrollable
	☐ Infection	☐ 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	☐ Fall- Due to Mobility Issues
☐ Choked on Food	☐ Aspiration Due to Improper Diet Texture
☐ Medication Error	☐ Failure to Provide Timely Medical Care
☐ Fall-Due to Environmental Factors	☐ Staff Did Not Monitor Input/Output of Fluids

Other:_____

PREVENTION MEASURES:

☐ Physical/Social Environmental Change	☐ Medication Changes
☐ Agency Policy/System Change	☐ Follow up Appointment Scheduled
☐ Staff Training	☐ PT/OT/Speech Referral made to address communication or mobility concern
☐ Counseling	☐ Diet Change Ordered
☐ Team Meeting to address ISP Changes	☐ Home Health Care
☐ Appointment with Medical Care Provider	

Other:_____

INVESTIGATIVE AGENT REVIEW:

Comments & Questions:

_____
_____
_____
_____
_____
_____
_____
_____

IA NAME: _____ Review Completed Date: _____