

ADMINISTRATIVE REVIEW FORM FOR UNANTICIPATED HOSPITALIZATION

Individual's Name: _____

Date of Unanticipated Hospitalization: _____

Major Unusual Incident Number: _____

Date Form Initiated: _____

Name of Person Initiating Form: _____

Title of Person Initiating the Form: _____

Contact Information for Person Initiating Form: _____

Provider Name: _____

PART 1 – TO BE COMPLETED BY THE INDIVIDUAL'S PROVIDER

DESCRIPTION – Indicate which situation applies.

- Hospital admission lasting 48 hours or longer due to one or more of the specified diagnoses (i.e. aspiration pneumonia, bowel obstruction, dehydration, medication error, seizures, or Sepsis.)
- Hospital re-admission lasting 48 hours or longer due to any diagnosis that is the same diagnosis as a prior hospital admission lasting 48 hours or longer within the past 30 calendar days.

HISTORY/ANTECEDENTS: Explain what led to the unanticipated hospitalization.

Describe the medical history of the individual.

Have there been recent similar illnesses?

If so, please describe the illness and date or the occurrence,

What was the health of the individual in the 72 hours leading up to the hospitalization?

Did the individual complain of feeling unwell or deviate from routine (e.g., change in behavior, eating, sleeping, or bathroom habits)?

SYMPTOMS AND RESPONSE - What were the individual's symptoms (e.g., fever, rash, bloody stool, or trouble breathing) and over what length of time?

What actions did the provider take to address the symptoms?

PART 2 – TO BE COMPLETED BY THE INVESTIGATIVE AGENT IN COLLABORATION WITH THE INDIVIDUAL’S TEAM

DETAILS OF HOSPITALIZATION

Date of Admission: _____

Date of Discharge: _____

WHEN UNANTICIPATED HOSPITALIZATION IS BASED ON A HOSPITAL ADMISSION LASTING 48 HOURS OR LONGER DUE TO ONE OR MORE OF THE FOLLOWING DIAGNOSES

Indicate which apply:

- | | |
|---|--|
| <input type="checkbox"/> Aspiration Pneumonia | <input type="checkbox"/> Medical Error |
| <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Sepsis |

WHEN UNANTICIPATED HOSPITALIZATION IS BASED ON A HOSPITAL RE-ADMISSION LASTING 48 HOURS OR LONGER DUE TO ANY DIAGNOSIS THAT IS THE SAME DIAGNOSIS AS A PRIOR HOSPITAL ADMISSION LASTING 48 HOURS OR LONGER WITHIN THE PAST 30 CALENDAR DAYS

Indicate the diagnosis of the hospitalizations:

Provide the dates of the prior hospital admission and discharge:

DISCHARGE SUMMARY – Attach discharged summary.

FOLLOW-UP APPOINTMENT/CHANGES TO MEDICATION/CONTINUING CARE – List the changes and the continuing needs of the individual.

The person responsible for these changes. _____

Confirm follow-up appointments have been made. _____

CAUSES AND CONTRIBUTING FACTORS

- | | |
|--|--|
| <input type="checkbox"/> Medication change | <input type="checkbox"/> Failure to monitor input/output of fluids |
| <input type="checkbox"/> Medication error | <input type="checkbox"/> Failure to follow bowel protocol |
| <input type="checkbox"/> Aspiration due to improper diet texture | <input type="checkbox"/> Failure to provide timely medical care |
| <input type="checkbox"/> Refusal to follow diet | <input type="checkbox"/> Failure to monitor urination and/or bowel movements |
| <input type="checkbox"/> Insufficient fluid intake | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic medical diagnosis that places individual at higher risk | |
| <input type="checkbox"/> Refusal of staff assistance | |
| <input type="checkbox"/> Lack of health care coordination | |

ADMINISTRATIVE REVIEW SUMMARY AND CONCLUSION

PREVENTION PLAN – Describe the prevention plan being implemented to address causes and contributing factors (e.g., environmental change, staff training, medication changes, or diet change).

Name of Investigative Agent Completing Form: _____

Date Form Completed: _____