EASA PROGRAM – HOSPITALIZATIONS

(Complete ONE hospitalization form per hospitalization, updating as new information becomes available)

AGENCY IDENTIFIERS – *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Client (Agency) ID # _____ **Prime # (OHP ID)** _____

County of Residence _____ **Agency Name** _____

HIPAA IDENTIFIERS - *Entered at 'Participant' level – please update any 'Unknown' or 'Missing' values*

Full Name _____ **DOB** __ __ / __ __ / __ __

ADMIT DATES – *Report year and quarter of admit NOT the year and quarter reported to the EASA program*

Admit Date __ __ / __ __ / __ __

Admit Year | | | | | **Admit Quarter** ○ 1 Jan-Mar ○ 2 Apr-Jun ○ 3 Jul-Sep ○ 4 Oct-Dec

HOSPITALIZATION DETAILS

Hospital Name _____

Admit Type

- ○ Voluntary
- ○ Involuntary
- ○ Unknown

Type of Hospitalization

- ○ State Hospital
- ○ Acute Hospitalization
- ○ Emergency Room – Less than 1 day
- ○ Emergency Room – Extended Stay (over 1 day)
- ○ Substance Abuse
- ○ Residential Treatment
- ○ Sub-Acute Care
- ○ Other, specify _____
- ○ Unknown

If patient is still in the hospital you will need to enter number of days hospitalized

DISCHARGE DATES – *Report year and quarter of discharge NOT the year and quarter reported to the EASA program*

If patient is still in the hospital at time of initial data entry, check 'still in hospital' in REDCap.

Discharge Date __ __ / __ __ / __ __

Discharge Year | | | | | **Discharge Quarter** ○ 1 Jan-Mar ○ 2 Apr-Jun ○ 3 Jul-Sep ○ 4 Oct-Dec

If the exact admit and/or discharge date are unknown please specify the approximate days in hospital below.

Days in Hospital _____