

**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/ Medicaid ID) \_\_\_\_\_ Client Initials \_\_\_\_\_

**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 \_\_\_/\_\_\_/\_\_\_  Still in hospital

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 enter the approximate days in hospital below.*

Days in Hospital \_\_\_\_\_