HOSPITALIZATION FORM

ID NUMBER: | | | | | | | | FORM CODE: | H | O | S | DATE: 03/11/2015 Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year) 0b. Staff ID: ☐☐☐

Instructions: *This form should be completed during the interview portion of the participant's follow-up. The Date is the day the contact was made or is the date the status determination was made. Special missing values are allowed for cases where the response "Don't know", "Refused", "Unknown", or "N/A" is not listed as an option.*

1. Since our last contact, were you hospitalized or did you stay in a hospital observation unit for any reason?

Yes..... ☐
No ..... ☐ → **END**

HOSPITALIZATION #1

1a. Hospitalization Reason: ..... ☐

A= Heart attack
B= Blood Clot
C= Stroke/TIA
D= Fall
E= Other

1a1. If other, specify: _____

1b. Hospital Name, City, State: _____

1c. Specify hospital name, city, and state if not in drop down list: _____

1d. Approximate date of hospitalization ☐☐/☐☐☐☐ (Month / Year)

HOSPITALIZATION #2

2a. Hospitalization Reason: ..... ☐

A= Heart attack
B= Blood Clot
C= Stroke/TIA
D= Fall
E= Other

2a1. If other, specify: _____

2b. Hospital Name, City, State: _____

2c. Specify hospital name, city, and state if not in drop down list: _____

2d. Approximate date of hospitalization ☐☐/☐☐☐☐
Month Year