|  |  |  |  |
| --- | --- | --- | --- |
| **DODD – Possible or Determined MUI Report Form** | | | |
| Provider Name & Address | | | |
| Individual’s Name: | | DOB: | |
| Address: | | City/County: | |
| Date of Incident: Time of Incident: AM/PM | | | |
| Location of Incident (home in bathroom, at the mall, lunchroom at work): | | | |
| Description of Incident (Who, What, Where, When): | | | |
| Injury – Describe Type & Location: | | | |
| Immediate Action to Ensure Health & Welfare of Individuals: | | | |
| Name of PPI(s): | Relationship to Individual: | | |
| Witnesses to Incident: | Others Involved: | | |
| Type of Notification | Name/Title | | Date/Time |
| Guardian / Advocate/Family |  | |  |
| SSA |  | |  |
| Licensed or Certified Provider |  | |  |
| Staff or Family living at the Individual’s home |  | |  |
| LE (Name, Badge Number, Jurisdiction, Contact Info) |  | |  |
| Children’s Services (if applicable) |  | |  |
| County Board |  | |  |
| Administrator (Required for ICF) |  | |  |
| Senior Management |  | |  |
| Other Providers of Service |  | |  |

Additional Information/or Administrative Follow-Up: A. Further Medical Follow-up:

B. Administrative Action:

Printed Name:

Signature: Title: Date:

Body Part Injured:

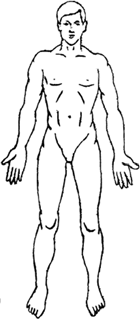
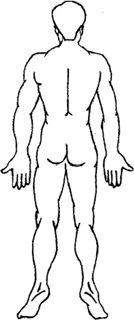
0 Head or Face 0 Neck or Chest

0 Mouth / Teeth 0 Abdomen

0 Hands / Arms 0 Back / Buttocks

0 Feet / Legs 0 Genitals

0 Other



Causes and Contributing Factors:

Preventive measures: (For Provider’s internal use)

Administrator Review:

Date:

DODD MUI UNIT INCIDENT REPORT DECEMBER 2018