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| .Provider |
| DODD – Possible or Determined MUI Report Form |
| 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, W hat, W here, W hen): |
| 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 |  |  |
| SSA (required for Independent Providers0 |  |  |
| Licensed or Certified Provider |  |  |
| Staff or Family living at the Individual’s home & responsible for the individual’s care. |  |  |
| LE (Name, Badge Number, Jurisdiction, and contact information required for Law Enforcement |  |  |
| CSB (Name and contact information required for Children Services) |  |  |
| County Board |  |  |
| Administrator (Required for ICF) |  |  |
| Support Broker (If applicable) |  |  |

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

Title \_ Date: