

Provider Name & Address:

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, 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		
SSA (required for Independent Providers)		
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)		
CPSA (Name and contact information required for Children Services)		
County Board		
Administrator (Required for ICF)		
Support Broker (If applicable)		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

B. Administrative Action:

Signature:

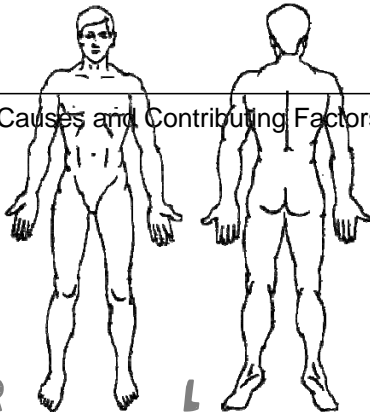
Title:

Date:

Body Part Injured:

- | | |
|-------------------------------------|---------------------------------------|
| <input type="radio"/> Head or Face | <input type="radio"/> Neck or Chest |
| <input type="radio"/> Mouth / Teeth | <input type="radio"/> Abdomen |
| <input type="radio"/> Hands / Arms | <input type="radio"/> Back / Buttocks |
| <input type="radio"/> Feet / Legs | <input type="radio"/> Genitals |
| <input type="radio"/> Other _____ | |

Causes and Contributing Factors:



Preventive measures: (For Provider's internal use)

Administrator Review: _____

Date: _____