Lake County Board of Developmental Disabilities/Deepwood
UI/MUI REPORTING FORM
CONFIDENTIAL

Individual Name: _____ Reporting Provider:_____

Individual Address: _____
Complete one report for each incident or injured individual. Report should be completed immediately.

PART I Completed by employee who discovered the incident

A. Date of Incident____/____/_____ B. Time _____:_____Military C. Day of Week: ☐ Mon ☐Tues ☐Wed ☐Thurs ☐ Fri ☐ Sat ☐Sun D. Witnessed? ○Yes ○ No

E. Others involved (Aggressor, Victim or Other) ODODD#_____(A, V or O) ODODD#_____

Specific Location and address where incident occurred::

Location_____ Address:_____
(e.g. ARC @ AB Dining Room)

F. Describe incident in detail including preceding or contributing events/action, identification of parties **(use staff names)** involved in the incident and the resolution of the incident (Use supplemental form if more space is needed):

Before the incident:_____

During the incident:_____

After the incident:_____

Were there witnesses (besides yourself)? ☐Yes ☐No (if alleged abuse/neglect, use ODODD# instead of name for any individual served as witnesses)

Witness' Name: Title:

Witness' Name: Title:

Signature: Date Completed: ____/__/__/__ Time: __:__ (Military)

Print Name: Title:

NOTIFICATION
Manager: (name)_____Date:_____/_____/_____ Time:____:____(Military)

Med Pers.: (name)_____Date:_____/_____/_____ Time:____:____(Military)

PART II Completed by LPN, RN or STAFF if no nurse available

If nursing available, stop here: Nurse Completes. If no Nurse, Staff Complete.

G. Nature of injury/illness

- ☐ 1. None/NA
- ☐ 2. Bruise
- ☐ 3. Airway obstruction
- ☐ 4. Bite
- ☐ 5. Burn
- ☐ 6. Exposure to cold/heat
- ☐ 7. Eye Injury
- ☐ 8. Head Injury
- ☐ 9.Laceration/ Scratch/abrasion
- ☐ 10. Puncture
- ☐ 11. Skin irritation
- ☐ 12. teeth injury
- ☐ 13. Unable to determine
- ☐ 14 Other

H. Severity of injury/illness

- ☐ 1. No apparent injury/illness
- ☐ 2. Minor (temporary injury/illness; no further complications)
- ☐ 3. Moderate (Injury/illness not serious; requiring medical attention)
- ☐ 4. Severe (serious injury/illness requiring medical treatment and/or resulting in change in physical status)
- ☐ 5. Death

I. First aid/treatment given by:

- ☐ 1. None
- ☐ 2. Staff
- ☐ 3. RN/LPN
- ☐ 4. Physician
- ☐ 5. Other:_____

J. Required Emergency Services?

- ○ Yes
- ○ No

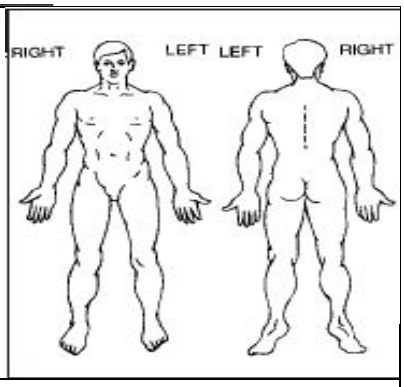
K. For medication/ Treatment Errors

- ☐ 1. Incorrect time
- ☐ 2. Incorrect medication
- ☐ 3. Incorrect dosage
- ☐ 4. Incorrect route
- ☐ 5. Incorrect individual
- ☐ 6. Omission
- ☐ 7. Transcription error
- ☐ 8. Stray pills
- ☐ 9. Other_____

INDIVIDUAL NAME:

PART II Contd. Completed by LPN, RN or STAFF if no nurse available.

L. Assessment/Treatment Time:____:____(Military)



Signature:_____Date completed:____/___/_____ Time: ____:____(Military)

Print Name:_____Title:_____

PART III M. NOTIFICATION:

LIST NAME OF PERSON SPOKEN TO (IF MESSAGE LEFT-LIST PHONE NUMBER)	DATE	TIME	Notified by: Print Name
Superintendent MUI Reporting Line (Board operated programs only x5113)	___/___/____	___:____(military)	
Physician:	___/___/____	___:____(military)	
Director of Nursing:	___/___/____	___:____(military)	
☐Family ☐Guardian (Check all that apply):	___/___/____	___:____(military)	
MUI Reporting Line (350-5253):	___/___/____	___:____(military)	
Residential Provider:	___/___/____	___:____(military)	
Day Program:	___/___/____	___:____(military)	
Child Protective Services (350-4000):	___/___/____	___:____(military)	
Law Enforcement:	___/___/____	___:____(military)	
Individual's SSA:	___/___/____	___:____(military)	
Other:	___/___/____	___:____(military)	
Fax 350-5143 (Potential MUIs Only):	___/___/____	___:____(military)	

PART IV Completed by Manager

Potential Major Unusual Incident ☐ Yes ☐No

All potential MUIs require notification to the MUI reporting line 440-350-5253 (LAKE)

N. Type of incident (See procedure):

O. One sentence summary of incident:

P. Immediate actions taken to ensure health/welfare (e.g. removed staff from duty, sent individual to ER):

Q. Possible causes and contributing factors for the incident:

R. Preventative Measures (Specific actions, by whom):

Signature:_____**Date Completed:**____/____/_____**Time** _____:_____**(Military)**

Print Name:_____**Title:**_____