

DODD – Possible or Determined MUI Report Form	
Provider Name & Address:	
Individual's Name:	DOB:
Address:	City/County
Date of Incident:	Time of Incident: AM <input type="checkbox"/> PM <input type="checkbox"/>
Location of Incident: (i.e. "home in bathroom", "at the mall", "lunchroom at work", etc)	Type of Incident:
Description of Incident (Who, What, Where, When): _____ _____ _____ _____ _____ _____ _____	
Injury – Describe Type & Location: _____ _____	
Immediate Action to Ensure Health & Welfare of Individual(s): _____ _____	
Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Signature and Date

Print Name

Type of Notification	Name/Title	Date/Time
Senior Management		
Guardian/Advocate/Family		
SSA/QIDP		
Licensed/Certified Provider or ICF Administrator		
Staff or Family living at the Individual's home		
Law Enforcement (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable) 440.350.4000		
County Board/MUI Line 440.350.5253		
Other Providers of Service		
Superintendent MUI Reporting Line (Board Operated Programs Only x5113)		

Submit all Incident Reports to UIR@lakebdd.org – Potential MUIs to UIR@lakebdd.org AND IA@lakebdd.org

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

B. Administrative Action:

Printed Name: _____

Signature: _____

Title: _____

Date: _____

Body Part Injured:

- Head or Face
- Mouth/Teeth
- Hands/Arms
- Feet/Legs
- Neck or Chest
- Abdomen
- Back/Buttocks
- Genitals

Detailed description of area(s) injured:

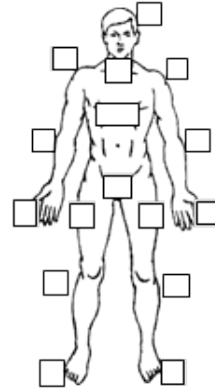
Print Name: _____

Signature: _____

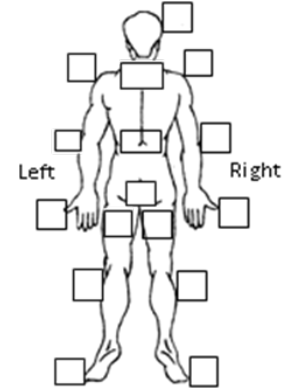
Date: _____

Check All Areas Injured

Anterior



Posterior



One Sentence Summary of Incident:

Causes and Contributing Factors:

Preventive Measures: (For Provider's internal use)

Administrator Review: _____

Date: _____