Ohio | Department of Developmental Disabilities

LCBDD/DEEPWOOD Policy A-10
Attachment A

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: (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

Ohio Department of Developmental Disabilities

LCBDD/DEEPWOOD Policy A-10
Attachment A

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 ☐Neck or Chest
☐Mouth/Teeth ☐Abdomen
☐Hands/Arms ☐Back/Buttocks
☐Feet/Legs ☐Genitals

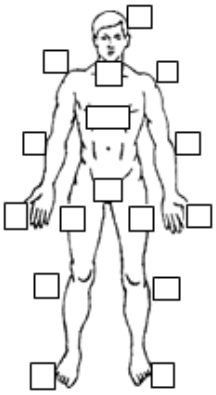
Detailed description of area(s) injured:

_____
_____
_____
_____
_____
_____

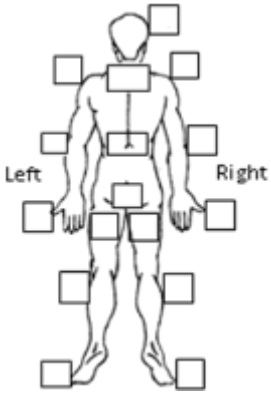
Print Name: _____
Signature: _____
Date: _____

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: _____