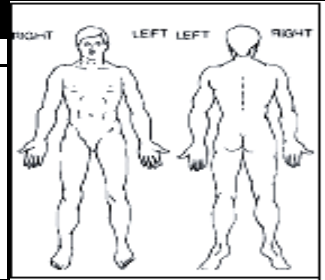


INDIVIDUAL NAME: _____

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

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



Signature: _____ Date: ____/____/____ Time: ____:____

Type 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 Reporting Line (Board Operated Programs Only x5113)			
Physician:			
Director of Nursing:			
Family Guardian (Check all that apply):			
MUI Reporting Line (350-5253):			
Residential Provider:			
Day Program:			
Child Protective Service (350-4000):			
Law Enforcement:			
SSA: _____ (e-mail: UIR@lakebdd.org)			
Other:			
Email MUI Incident Report to: IA@lakebdd.org (Potential MUIs Only)			

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: _____

O. One Sentence summary of incident:

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

Q. Possible Causes and Contributing Factors for the Incident:

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

Signature: _____ Date Completed: ____/____/____ Time: ____:____
Type Name: _____ Title: _____