

Provider Agency Name & Address:

**ODMRDD – 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 & Safety of Individuals:

Name of PPI(s):	Relationship to Individual:
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Witnesses to Incident:	Others Involved:
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Type of Notification	Name/Title	Date
Guardian / Advocate		
SSA		
Licensed or Certified Provider		
Staff or Family living at the individual's home & responsible for the individual's care.		
LE / CSB		
CPSA		
County Board		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

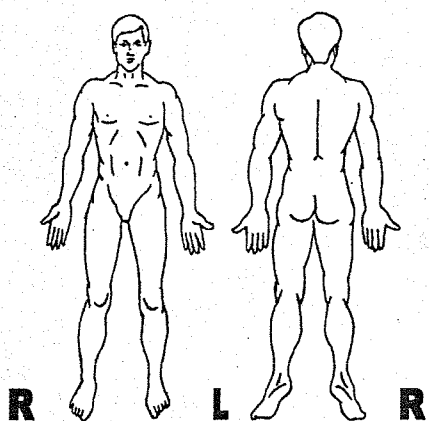
B. Administrative Action:

Signature:

Date:

Body Part Injured:

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



Preventive measures: (For Provider's internal use)