Board of Developmental Disabilities Services

MUI/UI INCIDENT REPORT

Individual's Name: **Complete first and last name (no initials or nicknames)** DOB: _____

Address: _____ City/Zip: _____

- **0-2 yrs – Developmental Spec.**
- **3-5 yrs – Intake/Transition Spec.**
- **6+ yrs - ESSA/SSA**

Reported by: **Person completing the form- not who gave you the information. (full name – no initials)** SSA/ITS/DS: _____

Discovered On: _____ Time: _____ ☐ AM ☐ PM

Reported On: _____ Time: _____ ☐ AM ☐ PM

Location of Incident: **Site of the incident (i.e. Community, Individual's home, Day Service site, etc.)**

Provider: **Provider responsible for client at time of incident**

MUI Subcategory:

☐ Physical Abuse	☐ Exploitation	☐ Attempted Suicide	☐ Accidental/Suspicious Death
☐ Sexual Abuse	☐ Law Enforcement	☐ Medical Emergency	☐ Death
☐ Verbal Abuse	☐ Misappropriation	☐ Significant Injury	☐ Unscheduled Hospitalization
☐ Neglect	☐ Missing Individual	☐ Failure to Report	☐ Unapproved Behavior Supp.
☐ Peer to Peer	☐ Rights Code Violation	☐ Prohibited Sexual Relation	☐

UI Subcategory: ☐ Behavioral ☐ Law Enforcement ☐ Medical ☐ Other

Summary of incident:

Who, What, When, Where, Why

Cause and Contributing Factors:

What lead up to the incident? If the factors are not known then indicate "unknown".

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Immediate Actions:

Steps taken directly after incident

Injuries:

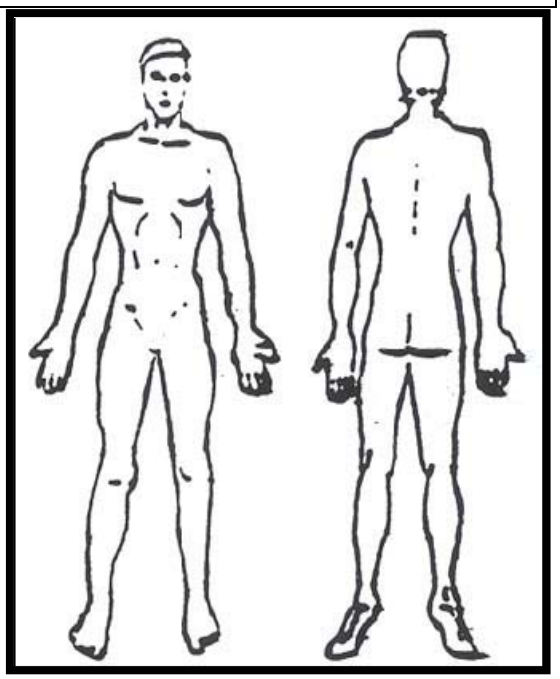
Location:

- ☐ Head/Face
- ☐ Arm/Hands
- ☐ Back
- ☐ Other (list in detail)
- ☐ Chest/Neck
- ☐ Leg/Feet
- ☐ Buttocks

Cause:

- ☐ Known
- ☐ Unknown

- **Was cause of injury known/unknown?**



Details of injury/Medical follow up:

1) **Include type of injury, side of body, body part**
2) **Treatment given: first aid, nurse, hospital, ER, etc.**

- **Complete first and last name – no initials**
- **Must be actual names – not a title or agency**

- **Include a complete date and time for every person notified.**

Notifications:	Name	Date	Time
☐ Supervisor			
☐ Investigative Agent-*(937)457-2765 phone-(937)457-2817 fax* Email to:mui@mcbdds.org			
☐ Case Manager - Email form to: ui@mcbdds.org			
☐ Law Enforcement - Jurisdiction:			
☐ Montgomery County Children's Services *(937) 224-5437 phone - (937) 277-1127 fax*			
☐ Provider			
☐ Guardian/Family Member			
☐ Other - Title:			
☐ Other - Title:			

MUI Notifications:

Legal guardian notified - *verbally notified within 24 hrs of MUI*	Date:	Time		☐	AM	☐	PM
DCS called	Date:	Time		☐	AM	☐	PM
DCS faxed	Date:	Time		☐	AM	☐	PM

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Others Involved:	Name	Title
☐ PPI		
☐ Witness		
☐ Witness		
☐ Other		
☐ Other		

Preventative Measures:

How do you plan on keeping this type of incident from happening again?

Corrective Measures: (Required for all MUI's)

Reporter's Name: **Can be an electronic signature.** Date _____