

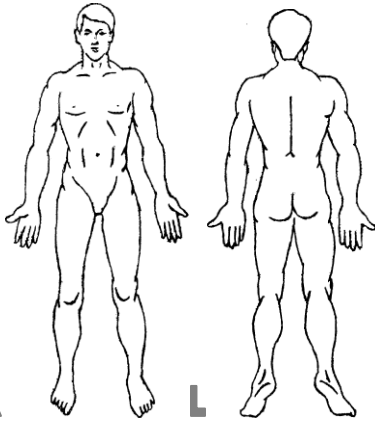
Muskingum County Board of Developmental Disabilities MUI/UI Form

Provider Name:		Address:		Date:	
Individual's Name:				DOB:	
Address:				City:	
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, Why and How):					
Immediate Action to Ensure Health & Safety of Individual(s): MUST COMPLETE					
Other Person(s) Involved: (person(s) who is alleged to have been responsible for the reported MUI/UI):				Relationship to Individual(s):	
Witnesses to Incident:				Others Involved:	
Type of Notification		Name/Title		Date	
Guardian and/or Person Identified					
SSA					
Provider					
Staff or Family living at the individual's home & responsible for the individual's care					
LE / CSB					
Support Broker					
UI Coordinator					
Routing boxes - completed by County Board Staff Only					
Route:	Fax to UI Coordinator (740) 455-4186		Building Supervisor		Nurse
Initials:					
Date:					

MUI/UI Reports must be completed within 4 hours

Is this a possible exposure? No Yes If Yes: Contact Nurse IMMEDIATELY

Behavior Support Plan in Place? No Yes



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/Arm	<input type="checkbox"/> Back/ Buttocks
<input type="checkbox"/> Feet/Legs	<input type="checkbox"/> Genitals
<input type="checkbox"/> Other:	<input type="checkbox"/>
Describe Injury (check one):	
<input type="checkbox"/> Laceration	<input type="checkbox"/> Scratch
<input type="checkbox"/> Bruise	<input type="checkbox"/> Other (describe):
Degree of Injury (check one):	
<input type="checkbox"/> Moderate	
<input type="checkbox"/> Severe	
Nurse Consulted :	<input type="checkbox"/> Yes <input type="checkbox"/> No
Doctor Consulted:	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Aide Administered:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Complete for injury/illness and describe:

Further Medical Follow-up:

Cause & Contributing Factors:

Preventive Measures:

Print Name:

Signature/Title:

Date:

UI Follow-up:

Administrative Action:
