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**:

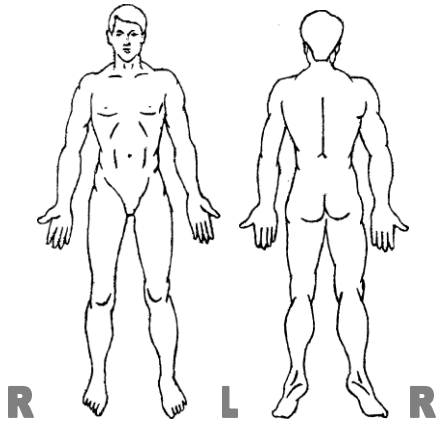
Type of Notification	Name/Title	Date
Guardian and/or Person Identified		
SSA		
Provider		
Staff or Family living at the individual's home & responsible for the individual's care		
LE / CSB		
Support Broker		
UI Coordinator		

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:	
☐ Head or Face	☐ Neck or Chest
☐ Mouth /Teeth	☐ Abdomen
☐ Hands/Arm	☐ Back/ Buttocks
☐ Feet/Legs	☐ Genitals
☐ Other:	☐
Describe Injury (check one):	
☐ Laceration	☐ Scratch
☐ Bruise	☐ Other (describe):
Degree of Injury (check one):	
☐ Moderate	
☐ Severe	
Nurse Consulted :	☐ Yes ☐ No
Doctor Consulted:	☐ Yes ☐ No
First Aide Administered:	☐ Yes ☐ No

Complete for injury/illness and describe:

Further Medical Follow-up:

Cause & Contributing Factors:

Preventive Measures:

Print Name:	**Signature:**	**Date:**

UI Follow-up:

Administrative Action: