DODD – Possible or Determined MUI Report Form

Provider Name & Address	
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 & Welfare of Individuals:	
Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian / Advocate/Family		
SSA		
Licensed or Certified Provider		
Staff or Family living at the Individual's home		
LE (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable)		
County Board		
Administrator (Required for ICF)		
Senior Management		
Other Providers of Service		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

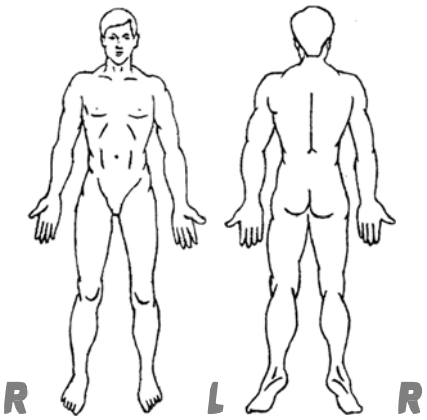
B. Administrative Action:

Printed Name: _____

Signature: _____ Title: Date:

Body Part Injured:

- O Head or Face
- O Mouth / Teeth
- O Hands / Arms
- O Feet / Legs
- O Other _____
- O Neck or Chest
- O Abdomen
- O Back / Buttocks
- O Genitals



Causes and Contributing Factors:

Preventive measures: (For Provider's internal use)

Administrator Review: _____ Date: _____