Department of
Developmental Disabilities

# 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:

Head or Face
Mouth / Teeth
Hands/Arms
Feet/Legs

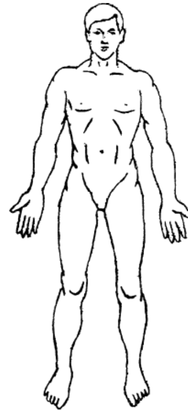
Neck or Chest
Abdomen
Back/Buttocks
Genitals

Detailed description of area(s) injured:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

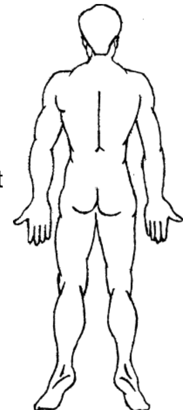
**Check All Areas Injured**

Anterior



Right Left

Posterior



Left Right

Causes and Contributing Factors:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Preventive measures: (For Provider's internal use)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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______________________________________________________________________________

Administrator Review: ______________________________ Date: __________________________