

DODD – Possible or Determined MUI Report Form					
Provider Name & Address					
Individual's Name:		DOB:			
Address:		City/County:			
Date of Incident: Time of Incident	ident: AN	M PM			
Location of Incident (home in bathroom, at the ma	ll, lunchroom at work):				
Description of Incident (Who, What, Where, Where	n):				
			_		
			_		
Injury – Describe Type & Location:			_		
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Immediate Action to Ensure Health & Welfare of Ir	ndividuals:				
Name of PPI(s):	Relationship to Indivi	idual			
name of PPI(s).	Relationship to indivi	idual.			
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 Administ A. Further Medical Follow-up:	rative Follow-Up:			
B. Administrative Action:				
Printed Name:Signature:		Title:		Date:
Body Part Injured:				
Head or Face Mouth / Teeth Hands/Arms Feet/Legs Detailed description of area(s) injured	Neck or Chest Abdomen Back/Buttocks Genitals	Right	Check All A	Posterior Left Right
Causes and Contributing Factors:				
Preventive measures: (For Provid	er's internal use)			
Administrator Review			Date:	