

# UI/MUI Report Form

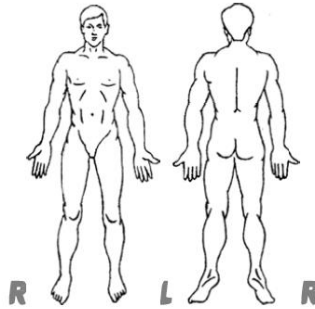
Initial Report – Call Received

<u>Provider Agency/Name &amp; Address:</u>				
<u>Reporter Name/Address/Phone Number</u>				
<u>Individual's Name:</u>	<u>DOB:</u>			
<u>Address:</u>	<u>Date of Incident:</u>  <u>Time of Incident:</u>			
<u>Location of Incident (home in bathroom, at the mall, lunchroom at work):</u>				
<p><b>Unusual Incident (CHECK ALL THAT APPLY)</b>  <u>Pick UI or MUI based on definitions.</u>  <i>An event or occurrence involving an individual which is not consistent with routine operations, policy, procedures, or the care and habilitation plan of the individual, but is not "abuse", "neglect", or a "major unusual incident".</i></p>	<p><b>Major Unusual Incident (CHECK ALL THAT APPLY)</b>  <i>Alleged, suspected, or actual occurrences of the following:</i></p>			
<p>1. <input type="checkbox"/> Medication Error</p> <p>2. <input type="checkbox"/> Fall w/injury</p> <p>3. <input type="checkbox"/> Non-MUI Peer to Peer</p> <p>4. <input type="checkbox"/> Other Non-MUI Injury</p> <p>5. <input type="checkbox"/> Overnight Relocation</p> <p>6. <input type="checkbox"/> Other (Explain)</p> <p>7. <input type="checkbox"/> ER Visit</p>	<p>8. <input type="checkbox"/> Injury – Self-Inflicted</p> <p>9. <input type="checkbox"/> Suicide Threat</p> <p>10. <input type="checkbox"/> Transportation</p> <p>11. <input type="checkbox"/> Atypical Behavior</p> <p>12. <input type="checkbox"/> Non-MUI Law Enforcement</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Abuse <span style="float: right;">Category A</span>  <input type="checkbox"/> Neglect  <input type="checkbox"/> Misappropriation  <input type="checkbox"/> Death: Accidental or Suspicious  <input type="checkbox"/> Exploitation  <input type="checkbox"/> Failure to Report  <input type="checkbox"/> Rights Violation  <input type="checkbox"/> Peer to Peer  <input type="checkbox"/> Prohibited Sexual Relations                 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Missing Person <span style="float: right;">Category B</span>  <input type="checkbox"/> Medical Emergency  <input type="checkbox"/> Significant Injury: <input type="checkbox"/> Known <input type="checkbox"/> Unknown  <input type="checkbox"/> Death: Not Accidental or Suspicious  <input type="checkbox"/> Suicide Attempt  <hr/> <input type="checkbox"/> Unauthorized Behavior Support  <input type="checkbox"/> Unscheduled Hospitalization <span style="float: right;">Category C</span>  <input type="checkbox"/> Law Enforcement  <p style="text-align: right; font-size: small;">*Please fill out a Category C Form</p> </td> </tr> </table>	<input type="checkbox"/> Abuse <span style="float: right;">Category A</span> <input type="checkbox"/> Neglect <input type="checkbox"/> Misappropriation <input type="checkbox"/> Death: Accidental or Suspicious <input type="checkbox"/> Exploitation <input type="checkbox"/> Failure to Report <input type="checkbox"/> Rights Violation <input type="checkbox"/> Peer to Peer <input type="checkbox"/> Prohibited Sexual Relations	<input type="checkbox"/> Missing Person <span style="float: right;">Category B</span> <input type="checkbox"/> Medical Emergency <input type="checkbox"/> Significant Injury: <input type="checkbox"/> Known <input type="checkbox"/> Unknown <input type="checkbox"/> Death: Not Accidental or Suspicious <input type="checkbox"/> Suicide Attempt <hr/> <input type="checkbox"/> Unauthorized Behavior Support <input type="checkbox"/> Unscheduled Hospitalization <span style="float: right;">Category C</span> <input type="checkbox"/> Law Enforcement <p style="text-align: right; font-size: small;">*Please fill out a Category C Form</p>
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<p><u>Description of Incident (who, what, where, when, why, how):</u> <i>What happened – what was going on? Why it happened? How it happened? Who was involved? One primary person completes the form. Witness to incident submits written statement to be attached.</i></p>				
<p><u>Injury – Describe Type &amp; Location:</u> <b><u>Describe thoroughly or NA if no injury.</u></b></p>		<p><input type="checkbox"/> Other information attached.</p>		

# UI/MUI Report Form

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 / Arms  | <input type="checkbox"/> Back / Buttocks |
| <input type="checkbox"/> Feet / Legs   | <input type="checkbox"/> Genitals        |
| <input type="checkbox"/> Other: _____  |  |



Immediate Action to Ensure Health & Safety:

*What did you do at that time to make sure people were safe?*

Reporting Staff Signature:

Title:

Date:

Name of PPI:

Relationship to Individual:

DOB of PPI:

Witnesses to Incident:

Others Involved:

Type of Notifications	Name	Email	Phone	Date/Time:
Program Manager				
Bldg. Coordinator				
Adult Services Director				
Superintendent				
SSA		@clermontdd.org		
Licensed or Certified Provider				
Staff or Family living at the individual's home & responsible for the individual's care.				
Law Enforcement (Name & contact information)				
CPSA (Name & contact information)				
Investigative Agent				
Support Broker (If applicable)				
Guardian/Advocate				
Other:				

Guardian Address:

Additional Information/or Administrative Follow-up:

A. Further Medical Follow-up:

B. Administrative Action:

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Administrator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## MUST Be Completed After Internal Review

Causes and Contributing Factors:

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### Prevention Plan

**WHAT** is the plan to prevent future/additional incidents? Make the steps "action oriented" whenever possible and time specific. Have other significant factors that played a part in the incident been addressed?

**Who** is responsible for ensuring the plan/action steps are implemented?

**When** will plan/action steps be initiated/completed(Date)

**Who** is responsible for follow up? Staff training? Who will verify the outcome of the action steps?

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Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_