UI/MUI Report Form

☐ Initial Report – Call Received

Provider Agency/Name & Address

Reporter Name/Address/Phone Number

Individual's Name	DOB
Address:	Date of Incident: Time of Incident:

Location of Incident (home in bathroom, at the mall, lunchroom at work)

Unusual Incident (CHECK ALL THAT APPLY)

Pick UI or MUI based on definitions.

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".

1. ☐ Medication Error
2. ☐ Fall w/ injury
3. ☐ Non-MUI Peer - Peer
4. ☐ Other Non-MUI Injury
5. ☐ Overnight Relocation
6. ☐ Other (Explain)
7. ☐ ER Visit
8. ☐ Self-Inflicted Injury
9. ☐ Suicide Threat
10. ☐ Transportation
11. ☐ Atypical Behavior
12. ☐ non-MUI Law Enforcement

Major Unusual Incident (CHECK ALL THAT APPLY)

Pick UI or MUI based on definitions.

Alleged, suspected, or actual occurrences of the following:

Category A

- ☐ Abuse
- ☐ Neglect
- ☐ Misappropriation
- ☐ Death: Accidental / Suspicious
- ☐ Exploitation
- ☐ Failure to Report
- ☐ Rights Violation
- ☐ Peer to Peer
- ☐ Prohibited Sexual Relations

Category B

- ☐ Missing Person
- ☐ Medical Emergency
- ☐ Significant Injury: ☐ Known ☐ Unknown
- ☐ Death: Not Accidental / Suspicious
- ☐ Suicide Attempt

Category C

- ☐ Unauthorized Behavior Support
- ☐ Unscheduled Hospitalization
- ☐ Law Enforcement

*****Please fill out a Category C Form

Description of Incident (who, what, where, when, why, how): *What happened – what was going on? Why did it happen? How did it happen? Who was involved? One primary person completes the form. Witness to incident submits written statement to be attached.*

Injury – Describe Type & Location ***Describe thoroughly or NA if no injury.*** ☐ Other information attached.

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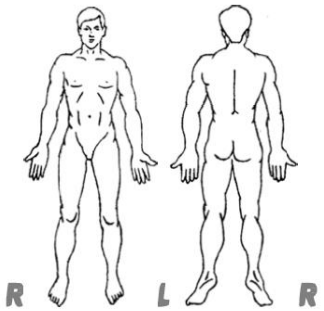
Body Part Injured:

- ☐ Head or Face
- ☐ Mouth / Teeth
- ☐ Hands / Arms
- ☐ Feet / Legs
- ☐ Other: ____
- ☐ Neck or Chest
- ☐ Abdomen
- ☐ Back / Buttocks
- ☐ Genitals



Immediate Action to Ensure Health & Safety: **What did you do at that time to make sure people were safe?**

Reporting Staff Signature: Title: Date:

As the initial reporter and author of this incident report, are you ok with this report being distributed to the Team?

- ☐ YES to all Team members
- ☐ ONLY to the following Team Members_____
- ☐ NO to distributing to anyone except the Investigations Team

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)				
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:

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

Signature: _____ Title: _____ Date: _____