

PROVIDER INITIAL MUI REPORT FORM

COUNTY OF SUMMIT DEVELOPMENTAL DISABILITIES BOARD

MUI UNIT PHONE: 330-634-8684

MUI UNIT FAX: 330-634-8553

THIS FORM COMPLIES WITH THE ODMR/DD FORMAT REQUIRED BY THE MUI RULE

PLEASE PRINT & COMPLETE EACH SECTION

MUI Category:

<input type="checkbox"/> Abuse (Physical)	<input type="checkbox"/> Abuse (Sexual)	<input type="checkbox"/> Abuse (Verbal)	<input type="checkbox"/> Neglect	<input type="checkbox"/> Peer to Peer Acts
<input type="checkbox"/> Misappropriation	<input type="checkbox"/> Exploitation	<input type="checkbox"/> Failure to Report	<input type="checkbox"/> Rights Violation	<input type="checkbox"/> Prohibited Sexual Relations
<input type="checkbox"/> Known Injury	<input type="checkbox"/> Unknown Injury	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Medical Emergency
<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Missing Person	<input type="checkbox"/> Death	<input type="checkbox"/> Unapproved Behavior Support	

Individual's Full Name:	DOB:	Residential Provider:	Day Program:	Funding Source:
Street:		City:	Zip:	Telephone number:
Date of Incident:		Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Provider and Location of incident:	
Date you became aware of the Incident: Time: <input type="checkbox"/> AM <input type="checkbox"/> PM		Supervision Level:	Behavior plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Behavior Plan Expires:	
Date/Time MUI written report faxed to the MUI Unit:		Supervision level met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Restraint used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Type: How long?	

Is there an injury? Yes No Photos: Yes No Hospital: ER Only Admit

Describe the injury: (Color, size, shape etc.)

Location on the body where the injury occurred:

Describe immediate action taken to ensure the health and safety of the individual:

<p><u>Primary Person Involved (PPI-Person accused)</u></p> <p>Full Name:</p> <p>Address:</p> <p>City: State: Zip:</p> <p>Telephone #:</p> <p>Date of Birth:</p> <p>Relationship to the Individual:</p>	<p><u>Witnesses/Relationship (include clients as applicable):</u></p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left;"><u>Name</u></th> <th style="text-align: left;"><u>Relationship:</u></th> <th style="text-align: left;"><u>Phone #</u></th> </tr> </thead> <tbody> <tr><td>1.</td><td></td><td></td></tr> <tr><td>2.</td><td></td><td></td></tr> <tr><td>3.</td><td></td><td></td></tr> <tr><td>4.</td><td></td><td></td></tr> <tr><td>5.</td><td></td><td></td></tr> </tbody> </table>	<u>Name</u>	<u>Relationship:</u>	<u>Phone #</u>	1.			2.			3.			4.			5.		
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