

Unusual Incident Report

Please Print

05/10/2019

After Hours Reporting: (440) 282-1131 MUI Fax: (440) 326-0247 Email: MUI@murrayridgecenter.org

Individual's Name: _____

Individual's Address: _____

Provider Contact Person: _____ **Phone Number:** _____

Date Incident Occurred (M/D/Y): _____ **Time of Incident:** _____ AM PM

Date Incident Discovered (M/D/Y): _____ **Time of Discovery:** _____ AM PM

Specific Location Where Incident Occurred: _____

Date Incident Reported (M/D/Y): _____ **Time of Report:** _____ AM PM **Supervisor:** _____

Date Reported to IA - for MUI only (M/D/Y): _____ **Time of Report:** _____ AM PM **IA:** _____

Description of Incident (who, what, when, where): ~ add additional sheet(s) as necessary

Witnesses:

Name: _____ Title: _____ Phone #: _____

Name: _____ Title: _____ Phone #: _____

Staff Signature: _____ **Title:** _____ **Date:** _____

Printed Name: _____

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Individual's Name: _____

Primary Person(s) Involved and their relationship to individual: *(Primary Person Involved means the person alleged to have committed or to have been responsible for abuse, accidental or suspicious death, exploitation, failure to report, misappropriation, neglect, prohibited sexual relations, or rights code violation.)*

Name and Relationship: _____

Did Injury Occur: Yes No

Assessment Completed by Whom? _____ Title: _____ Date: _____

Type and location of Injury: _____

Was Emergency Transport required to hospital? Yes No By whom? _____

Name of Hospital: _____ ER Treatment only? Yes No Hospital Admittance? Yes No

Describe immediate action taken to ensure health and welfare of the individuals involved and any at-risk individuals:

Describe any further medical follow-up required:

REQUIREMENTS FOR IMMEDIATE REPORTING TO INVESTIGATE AGENTS (IAs): *Alleged Abuse, Neglect, Exploitation, Misappropriation, Peer-to-Peer Acts, Prohibited Sexual Relations, Accidental or Suspicious Death, or Media Inquiries about an MUI must be verbally reported to an IA within 4 hours of the discovery of the incident.*

REQUIRED NOTIFICATIONS FOR A UI:

UI notification to other providers of services as necessary to ensure continuity of care and support for the individual.

Provider Name: _____ Title: _____ Date: _____ Time: _____ AM PM

Provider Name: _____ Title: _____ Date: _____ Time: _____ AM PM

Provider Name: _____ Title: _____ Date: _____ Time: _____ AM PM

Independent providers must notify guardian/identified other and send completed UI Report to SSA by the next working day after discovery of UI.

Guardian/Identified Other: _____ Date: _____ Time: _____ AM PM

SSA: _____ Date: _____ Time: _____ AM PM

REQUIRED NOTIFICATIONS FOR A POTENTIAL OR IDENTIFIED MUI:

The following MUI notification must be made on the day of occurrence, or discovery, of an MUI incident and include immediate action taken.

Guardian /Identified Other: _____ Date: _____ Time: _____ AM PM

SSA: _____ Date: _____ Time: _____ AM PM

Residential Provider: _____ Date: _____ Time: _____ AM PM

Residential Staff/Family: _____ Date: _____ Time: _____ AM PM

Law Enforcement: _____ Date: _____ Time: _____ AM PM

Children Services: _____ Date: _____ Time: _____ AM PM

Other Provider: _____ Date: _____ Time: _____ AM PM

Other Provider: _____ Date: _____ Time: _____ AM PM

Other Provider: _____ Date: _____ Time: _____ AM PM

Staff Signature: _____ Title: _____ Date: _____

Printed Name: _____