Lorain County Board of Developmental Disabilities – Murray Ridge Center

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: _____