Knox County Board of DD Report for Unusual Incident or MUI

Individual's name: ______ DOB: ______

Date of incident: ______ Time of incident ______ ☐AM ☐PM

Name of provider: ______

Individual's Address: ______ Specific location that incident occurred: ______

Incident Type:

☐ Injury ☐ Illness ☐ Behavior ☐ Fall ☐ Medication error ☐ Missing person ☐ Theft/Missing Item
Aggressive towards: ☐ Peers ☐ Self ☐ Staff ☐ Law Enforcement Called ☐Other:

Restraint:

Restraint used? ☐N/A ☐No ☐Yes If yes, # of minutes____ restraint used Approved Restraint? ☐No ☐Yes
Type of Restraint: _____ Restraint used according to individual's ISP? ☐No ☐Yes

Injury Location:

If injury occurred, give *specific* location on *body:* ☐ Head/Face ☐ Mouth/Teeth ☐ Hands/Arms
☐ Feet/Legs ☐ Neck/Chest ☐ Abdomen ☐ Back/Buttocks ☐ Genitals ☐ Other:

Type of Injury or Illness:

☐ No apparent injury ☐ Scratch ☐ Eye Injury ☐ Chest Pain ☐ Headache
☐ Fracture (broken bone) ☐ Bruise ☐ Head Injury ☐ Fever ☐ Toothache
☐ Sprain/Strain ☐ Puncture ☐ Stomach Ache ☐ Diarrhea ☐ Dizziness
☐ Laceration (cut) ☐ Burn ☐ Vomiting ☐ Respiratory/Coughing ☐ Fainting
☐ Abrasion (scrape) ☐ Dislocation ☐ Other: ______

First Aid:

Was first aid/medical care given by staff? ☐ No ☐ Yes ☐N/A
☐ Clean wound ☐ Rest time ☐ Oral medication ☐ 911 Called ☐ Taken to ER
☐ Eye wash ☐ Topical medication ☐ Taken home ☐ Taken to physician ☐ Physician called
☐ Bandage ☐ Cold pack/ice ☐ Taken to Urgent Care ☐ Neuro checks initiated
☐ Other: (describe) ______

Describe what was happening immediately prior to the incident:

Describe incident: (attach additional written statements as applicable)

Witness(es) to incident: ________________________

What immediate action was taken by whom to ensure health and welfare of the individual?

Name/Title of person completing report ____________ Signature ____________ Date ____________

Guardian (if applicable) must be notified on the day of incident

Name, date, time of notification(s) as applicable: Call KCBDD 501-4592 within 4 hrs. for MUI's or possible MUI's

	Name	Date:	Time:			Date:	Time:
Supervisor:		_____	_____	Residential/ADS Provider:		_____	_____
Administration		_____	_____	Family (responsible for care)		_____	_____
Guardian:		_____	_____	Nursing Dept:		_____	_____
County Board:		_____	_____	Other:	_____	_____	_____
Law Enforcement:		_____	_____	Other:	_____	_____	_____

Name/Title of person(s) making notification(s): ____________

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Incident Follow-up notes: (include any further information discovered, or action to be taken/needed)

Possible cause & contributing factors to this incident:

Preventative measures regarding future incidents:

Medical Follow-up:

Provider Follow-up: Notification of agency senior management (required within two (2) business days for misappropriation, neglect, physical or sexual abuse MUIs).

	Date:	Time:		
Name of Manager:	_____	_____	Response (If applicable):	_____

Name and title of person completing this section ____________ Date ____________

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Route incident report per agency Policy/Procedure

Form based on 2018 OAC 5123-17-02