

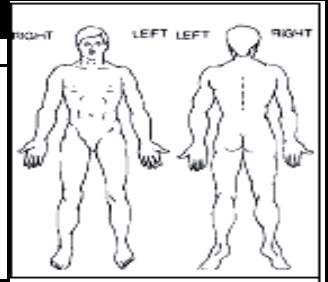


INDIVIDUAL NAME: \_\_\_\_\_

**PART II Contd-Completed by LPN,RN or STAFF if no nurse available**

**L. Assessment/Treatment** Time: \_\_\_\_\_ : \_\_\_\_\_ (Military)

\_\_\_\_\_



Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

Type Name: \_\_\_\_\_ Title: \_\_\_\_\_

**PART III M.NOTIFICATION:**

LIST NAME OF PERSON SPOKEN TO (if message left- list phone number)	DATE:	TIME:	Notified by: Print Name
Superintendent Reporting Line ( Board Operated Programs Only x5113)			
Physician:			
Director of Nursing:			
Family Guardian (Check all that apply):			
MUI Reporting Line (350-5253):			
Residential Provider:			
Day Program:			
Child Protective Service (350-4000):			
Law Enforcement:			
Individual's SSA:			
Other:			
Emailed MUI Incident Report to IA@lakebdd.org (Potential MUIs Only)			

**PART IV Completed by Manager**

**POTENTIAL Major Unusual Incident Yes No**  
(All potential MUIs require notification to the MUI Reporting Line 440-350-5253 (LAKE))

**N. Type of incident:**

**O. One Sentence summary of incident:**

\_\_\_\_\_

**P. Immediate actions taken to ensure health/welfare: (e.g. removed staff from duty; sent consumer to ER)**

\_\_\_\_\_

**Q. Possible Causes and Contributing Factors for the Incident:**

\_\_\_\_\_

**R. Preventative Measures ( Specific actions, by whom):**

\_\_\_\_\_

Signature: \_\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

Type Name: \_\_\_\_\_ Title: \_\_\_\_\_