☐ UI Log

Guernsey County Board of DD Incident Report

Individual's Name:	DOB:
Address:	City/County:
Date of Incident: Time of Incident: AM/PM	Date Co. Bd. Notified:

Location of Incident (home in bathroom, at the mall, lunchroom at work):

Description of Incident (Who, What, Where, When):

Injury—Describe Type & Location:

Immediate Action to Ensure Health & Safety of this Individual

Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Signature of Staff Completing the Form:

Signature of Others Involved:
By signing this, I agree with ALL information in the report.

Type of Notification	Name/Title & How	Date
SSA/ Program Office		
Guardian/Advocate		
Licensed or Certified Provider		
Family		

Additional Information/or Administrative Follow-Up

A. Further Medical Follow-up:

B. Administrative Action:

C. MUI: ____ yes ____ no

Nurse/Delegated Nurse's Note:

All Incidents involving an injury or a restraint was used must be reviewed by the nurse or delegated nurse.

Causes & Contributing Factors:

_____

_____

_____

_____

_____

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_____

_____

_____

Temp: _____ BP: _____ HR: _____ RR: _____

Nurse/Delegated Nurse's Signature:

Preventative Measures:

_____

_____

_____

Signature (s) of Reviewers: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

For all incidents after 4 PM, call (740) 260-3206 to report to an SSA.