



Serious Injury Report

State of Minnesota
Office of the Ombudsman for Mental Health and Developmental Disabilities
FAX: 651-797-1950



Date Reported: _____

County: _____

Client Information

Last Name: _____ First Name: _____ MI: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____) _____ Gender: ___M ___F Client Date of Birth: ___/___/___

Ethnic: _____ African American _____ Native American _____ Asian
_____ SE Asian _____ Hispanic _____ Caucasian
_____ Unknown

Guardianship: _____ None _____ Private Guardian/Conservator
_____ Public Guardian/Conservator _____ Representative Payee
_____ Power of Attorney _____ Unknown
_____ Parent

Legal Status: _____ Informal Admin (voluntary) _____ Stay of Commitment
_____ Committed _____ Psychopathic Personality
_____ Emergency Hosp/Court Hold _____ Rule 20 or 27
_____ Temp Placement _____ Respite Care
_____ Juvenile Court Comm _____ Inform Juvenile Adm by Parent
_____ Provisional Discharge _____ None

Client is currently receiving services for: _____ DD _____ MI _____ CD _____ ED
_____ MI&D _____ PP _____ MI/CD _____ MI/DD

Name of residence: _____

Corporation name: _____

Type of License: _____ Is client on or eligible for Medical Assistance? _____ Yes _____ No

Reporter Information

I wish to remain confidential and do not require a faxed/written response to this report.

Last Name: _____ First Name: _____

Title: _____ Telephone: _____ Fax: _____

Agency or program: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Injury Information

Date of Injury (if known): _____ Time of Injury: _____ a.m. or p.m.

Type of Injury:

- | | |
|---|---|
| <input type="checkbox"/> Minor Fracture | <input type="checkbox"/> Major Fracture |
| <input type="checkbox"/> Multiple Fractures Dislocation | <input type="checkbox"/> Internal Injuries |
| <input type="checkbox"/> Head Injury (with Loss of Consciousness) | <input type="checkbox"/> Laceration (muscle, tendon, or nerve damage) |
| <input type="checkbox"/> Burns (second or third degree) | <input type="checkbox"/> Eye Injuries |
| <input type="checkbox"/> Dental Injuries (avulsion of teeth) | <input type="checkbox"/> Ingestion of poison or harmful substances |
| <input type="checkbox"/> Near Drowning | <input type="checkbox"/> Heat Exhaustion/Sun Stroke |
| <input type="checkbox"/> Complication of previous injury | <input type="checkbox"/> Complication of medical treatment |
| <input type="checkbox"/> Other | |

Incident involved: Fall Client to Client Staff to Client
 Sports/Activity Related Suicide Attempt Self-injurious Behavior
 Restraint Procedure Unknown Other (explain) _____

Injury type specifics: _____

Describe how injury happened:

Name of Provider or Corporation where injury occurred: _____

Diagnosis Information

Axis I (Clinical Syndromes): _____

Axis II (Developmental/Personality Disorders) _____

Axis III (Physical Disorders) _____

Current Medications: _____

Others/Agencies Involved/Referred to/Notified:

- | | | |
|---|---|---|
| <input type="checkbox"/> Legal | <input type="checkbox"/> County | <input type="checkbox"/> MH Association |
| <input type="checkbox"/> Administration | <input type="checkbox"/> State Agency | <input type="checkbox"/> Medical |
| <input type="checkbox"/> Ombudsman | <input type="checkbox"/> Private Agency | <input type="checkbox"/> Other Government |
| <input type="checkbox"/> DHS | <input type="checkbox"/> Treatment Team | <input type="checkbox"/> Adult/Child Protection/CEP |
| <input type="checkbox"/> OHFC | | |

Additional Information: _____

