MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

332 Minnesota Street, Suite W1410,
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Voice – 651-757-1800
Toll Free – 800-657-3506
Fax – 651-797-1950
TTY/Voice – Minnesota Relay Service 711
https://mn.gov/omhdd

Serious Injury Report

Date of report: ______________________

(If all information is not available within 24 hours, please submit the report with the information you have.)

CLIENT INFORMATION

First Name:______________________________ MI:______ Last Name:______________________________

Client Facility Name (if applicable): ______________________________

Gender: ___ Female ___ Male ___ Other Date of Birth: ______________________

Ethnicity:

____ African
____ African American
____ American Indian or Native Alaskan
____ Asian
____ Caucasian or White
____ Choose Not to Respond
____ Hispanic or Latino
____ Other
____ Pacific Islander or Native Hawaiian

County of Residence: ______________________ County of Financial Responsibility: ______________________

Address Type: _____ Address at time of report (temporary)

_____ Permanent address (Home)

Client Address: ______________________________

______________________________ Apt/Suite#: ______________

City: ______________ County: ______________ State: ______________ Zip Code: __________

Client Home Number: ______________________ May we leave a message: ___ Yes ___ No

Client Mobile Number: ______________________

REPORTER INFORMATION

Do you wish to have your identity private? ____ Yes ___ No
Do you have concerns about retaliation? ____ Yes ___ No

First Name:______________________________ Last Name:______________________

Title:______________________________

Agency/Program Name (if applicable): ______________________________

Reporter Email address: ______________________________

Address:______________________________

______________________________ Apt/Suite#: ______________

City: ______________ County: ______________ State: ______________ Zip Code: __________

Contact Number: ______________________ Ext Number: ________

May we leave a message: ____ Yes ___ No

Mobile Number: ______________________ Fax Number: ______________________

Who else did you report this to? (check all that apply):

____ Administration
____ Adult or Child Protection or CEP
____ Attorney Legal
____ County Agency
____ Facility or Program or Agency Staff
____ Guardian or Legal Representative
____ Hospital Review Board
____ Law Enforcement
____ Licensing Agency
____ Medical Resources Health Care Provider
____ Office of Health Facility Complaints (OHFC)
____ Other – describe________________________________
____ Other Advocacy or Ombudsman Agency
____ Private Agency
____ State Agency
____ Treatment Team

ADDITIONAL CLIENT INFORMATION

Client Category (check all that apply):

____ Brain Injury
____ Chemical Dependency/Substance Use Disorder
____ Developmental/Intellectual Disabilities
____ Emotional Disturbance
____ Mental Illness
____ Mentally Ill and Dangerous
____ Other
____ Sex Offender

Legal Representatives (check all that apply):

____ Health Care Agent
____ Health Care Directive
____ None
____ Nonparent/Relative
____ Parent
____ Power of Attorney
____ Power of Attorney for Health Care Agent
____ Private Conservator
____ Private Guardian
____ Public Guardian
____ Representative Payee
____ Substitute Decision Maker (Commitment Statute 253B.092)
____ Tribal Custody

Legal Status (check all that apply):

____ Committed - Chemical Dependency (CD)
____ Committed - Developmental Disability (DD)
____ Committed - Mentally Ill (MI)
____ Committed - Mentally Ill and Dangerous (MI&D)
____ Committed - Sexual Psychopathic Personality (SPP)
____ Committed - Sexually Dangerous Person (SDP)
____ Emergency Hold Court Hold
____ Incarcerated (Jail or Prison)
____ Informal Juvenile Placement by Parents
____ Juvenile Court Placement
____ None
____ Probation
____ Provisional Discharge
____ Rule 20
____ Stay of Commitment
____ Unknown
____ Voluntary Admission

SERIOUS INJURY INFORMATION

Date of Injury (if known): ___________________ Time of Injury: _____________________ AM PM

Did the injury occur where the client lives? Yes No

If not, Name of Agency, Facility or Program where injury occurred (if applicable):

____

Address: ____

____

City:_______________________________State:_______________________Zip:______________

Telephone Number: ______________________ Fax: ___________________ County:________________

Location Where Serious Injury Occurred (check one):

_____ Adult Day Care Services
_____ Assisted Living Program – Class E
_____ Board and Lodge
_____ Board and Lodge Housing with Services
_____ Boarding Care Home
_____ Chemical Dependency Treatment Residential
_____ Children's Residential Facilities
_____ Community
_____ Crisis Home
_____ Crisis Respite Services
_____ Day Training and Habilitation Services
_____ Detox Services
_____ Family Adult Day Services
_____ Family Child Care
_____ Forensic Facility
_____ Foster Care

_____ Foster Care, Adult
_____ Foster Care, Child - DHS
_____ Foster Care, Child - DOC
_____ Group Home for DD
_____ Group Home for MI
_____ Halfway House
_____ Homeless
_____ Hospice – Class D
_____ Hospitals and Critical Access Hospital
_____ Incarcerated
_____ Job or Work (other than in program)
_____ Minnesota Sex Offender Program – Moose Lake
_____ Minnesota Sex Offender Program – Saint Peter
_____ Nursing Home
_____ Other - Describe ________________________________
_____ Outpatient Surgical Center
_____ Own home or Apartment
_____ Psychiatric Hospital
_____ Psychopathic Personality - Residential
_____ Relatives/Friends Home
_____ Residential Facilities for Adults with Mental Illness
_____ Residential Services for Persons with Physical Handicaps
_____ Residential Services, ICF/DD certified
_____ Residential Services, non-ICF/DD certified
_____ School
_____ Semi-Independent Living Services
_____ Shared Housing
_____ Sheltered Employment/Rehab
_____ Sober House
_____ State Operated Residential Treatment Facility for DD
_____ State Operated Residential Treatment Facility for MI
_____ Supervised Living Facility
_____ Temporary Placement
_____ Unknown
_____ Waiver Services, Residential Habilitation

Living Arrangement or Programs/ Services received (check all that apply):

_____ 245D Community Residential Setting - Adult
_____ 245D Community Residential Setting - Child
_____ 245D Home and Community Based Services - Adult
_____ 245D Home and Community Based Services - Child
_____ 245D Residential Facility (ICF/DD)
_____ Acute Care Hospital
_____ Adult Day Center/Facility
_____ Adult foster care
_____ Adult Rehabilitative Mental Health Treatment Center (ARMHS)
_____ Assertive Community Treatment (ACT)
_____ Behavioral Health Home
_____ Board and Lodge
_____ Board and Lodge with Services
_____ Boarding Care Home
_____ Certified Community Behavioral Health Clinic
_____ Child foster care
_____ Children's Residential Facility
_____ Children's Therapeutic Services and Supports
_____ Community Addiction Recovery Enterprise
_____ DBT provider (certified)
_____ Direct Care & Treatment – CBHH
_____ Direct Care & Treatment – AMRTC
_____ Direct Care & Treatment – CABHS
_____ Direct Care & Treatment – MSH
_____ Direct Care & Treatment – MSOCS
_____ Early Intensive Developmental & Behavioral Intervention
_____ Family Adult Day Services
_____ Forensic Nursing Home
_____ Foster Care Child - -Department of Corrections
_____ Home Care Provider: Class A, Class B, Class C, Class F
_____ Homeless
_____ Hospice – in facility
_____ Hospice – in home
_____ Housing with Services/Assisted Living
_____ Intensive Residential Treatment (IRTS)
_____ Lives at home with parents/family - Child
_____ Lives with Relatives
_____ Mental Health Center
_____ Minnesota Sex Offender Program
_____ Nursing Home
_____ Other
_____ Other Certified Treatment Provider
_____ Own apartment/home
_____ Residential treatment for adults with mental illness
_____ Shared Housing
_____ Substance use disorder treatment – Nonresidential
_____ Substance use disorder treatment – Residential
_____ Supervised Living Facility
_____ Wet House

Type of Injury (check one):

_____ Attempted Suicide
_____ Complication of medical treatment
_____ Complication of previous **injury**
_____ Concussion, no loss of consciousness requiring medical assessment
_____ Dental Injuries (avulsion of teeth)
_____ Dislocation
_____ **Extensive** Burns (second or third degree)
_____ **Extensive** Frostbite (second or third degree)
_____ Eye Injuries
_____ Fracture
_____ Head Injury with loss of consciousness
_____ Heat Exhaustion or Sun Stroke
_____ Ingestion of poison or **harmful** objects/substances
_____ Internal Injuries
_____ Lacerations involving tendons or organs
_____ Multiple Fractures
_____ Near Drowning
____ Other injury considered serious by Physician or HealthCare Professional (including self-injurious behavior, complications of treatment, delay of treatment & medication error)
_____ Potential Closed Head Injury

Circumstances Surrounding the Serious Injury (check all that apply):

_____ Attempted Suicide
_____ Client to client
_____ Fall
_____ Other – Describe________________________________

_____ Self-Injurious Behavior
_____ Sports/activity related
_____ Staff to client
_____ Restraint
_____ Unknown

Injury Type Specifics:
Describe how the serious injury occurred:
Describe the medical attention received and when:
Describe any medication changes since the time of serious injury:
Describe any follow-up appointments, assessments or medical services needed since the serious injury:
Describe any changes to the abuse prevention plan or individual programing as a result of the serious injury:

Describe any policies, protocols or staff training being implemented to address this issue:

DIAGNOSTIC INFORMATION

DD/ID and Personality Disorders:

Medical Conditions:

Psychiatric Dx:

MEDICATIONS (Use a separate sheet if necessary)

Medication Name	Dosage	Frequency

Please attach supporting documentation
Complete this form and fax to 651-797-1950