Serious Injury Report

State of Minnesota

Office of the Ombudsman for Mental Health and Developmental Disabilities

Fax: 651-797-1950

Date Reported: _____ County: Select a County

Client Information

Last Name: _____ First Name: _____ MI: _____

Street: _____

City: _____ State: Minnesota Zip: _____

Telephone Number: _____ Gender: Choose One Date of Birth: _____

Ethnic: Choose One Is Client on or Eligible for Medical Assistance: Choose Yes or No

Guardianship: Choose One

Legal Status: Choose One

Client is currently receiving services for: Choose One

Name of Residence: _____

Corporation Name: _____

Type of License: Choose One or Type in

Reporter Information

☐ I wish to remain confidential and do not require a response to this report.

Last Name: _____ First Name: _____

Title: _____ Telephone Number: _____ Fax: _____

Agency or program: _____

Street Address: _____

City: _____ State: Minnesota Zip: _____

Injury Information

Date of Injury (if known): _____ Time of Injury: _____ PM

Type of Injury: Choose One

Incident Involved: Choose One

Explain if you selected Other:

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:

- ☐ Legal
- ☐ Administration
- ☐ Ombudsman
- ☐ DHS
- ☐ OHFC
- ☐ County
- ☐ State Agency
- ☐ Private agency
- ☐ Treatment Team
- ☐ Ombudsman Staff
- ☐ MH Association
- ☐ Medical
- ☐ Other Government
- ☐ Adult/Child Protection/CEP

Additional Information:

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