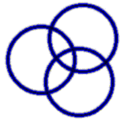

Serious Injury Report

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: Date of Birth:

Ethnic: Is Client on or Eligible for Medical Assistance:

Guardianship:

Legal Status:

Client is currently receiving services for:

Name of Residence:

Corporation Name:

Type of License:

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: Zip:

Injury Information

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

Type of Injury:

Incident Involved:
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	County	MH Association
Administration	State Agency	Medical
Ombudsman	Private agency	Other Government
DHS	Treatment Team	Adult/Child Protection/CEP
OHFC	Ombudsman Staff	

Additional Information: