Law Enforcement (Charged, Incarcerated, Arrested) Form

**Individual’s Name:** **Date Form Filled Out:**

**Incident Date: MUI Number:**

**Name of Person filling out Form:**

**Title: Agency:**

**Contact Information:**

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| **HISTORY / ANTECEDENTS:** |
| **Please list what led to the individual being charged, incarcerated, or arrested. Provide a timeline and whether this individual has a history of this behavior. Provide details of prevention measures from prior incidents.** |
| **CRIMINAL CASE INFORMATION:** |
| **Outcome of Criminal Case:** **Contact Information for Arresting Officer:****Incarceration Location****General Population?** |
| **SUPERVISION LEVEL:** |
| **Did the individual have a supervision requirement? If so, describe the supervision level. Was the supervision level met? Did the staff know about the supervision required? Was the staff trained on the implementation of the supervision requirements?** |
| **INJURIES / MEDICAL NEEDS:** |
| **Were there any injuries to the individual or anyone else involved in the LE MUI? Did the individual receive timely medical attention? Are the individual’s medical needs known – especially if the individual is incarcerated?**  |
| **DESCRIPTION:** |
| **Describe in detail the incident.** |
| **CAUSE AND CONTRIBUTING FACTORS:** |
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| * **Supervision not met**
* **Staff ratio was not appropriate**
* **Diet not followed**
* **Asked to complete task**
* **Change in Routine**
* **Excessive Noise**
* **1:1 Attention unavailable**
* **Peer aggression**
 | * **Outing Cancelled**
* **Control Issues-staff/family/peers**
* **Medication Change**
* **Illness**
* **Possible Hallucination**
* **Loss of Important Relationship**
* **ISP/BSP Not followed**
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**Other:** |
| **PREVENTION MEASURES:** |
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| * **Physical/Social Environmental Change**
* **Agency Policy/System Change**
* **Staff Training**
* **Counseling**
* **Team Meeting to address ISP Changes**
* **Appointment with Medical Care Provider**
 | * **Medication Changes**
* **Follow up Appointment Scheduled**
* **PT/OT/Speech Referral made to address communication or mobility concern**
* **Diet Change Ordered**
* **Home Health Care**
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**Other:** |
| **INVESTIGATIVE AGENT REVIEW:****Comments & Questions:****REVIEW COMPLETED DATE: IA NAME:** |