

SPECIAL NEEDS ALERT

SPONSORED BY THE BELMONT (MA) POLICE DEPARTMENT

(ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE USED UNLESS THERE IS CONSENT FROM THE PRIMARY CAREGIVER)

TODAYS DATE : ___/___/___

PATIENT IDENTIFICATION

Male Female || Juvenile

LAST NAME: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ DATE OF BIRTH: _____

TELEPHONE: _____ HEIGHT: _____ WEIGHT: _____

RESIDES WITH: _____ HAIR COLOR: _____

RELATIONSHIP: _____ EYE COLOR: _____

LOCAL CONTACTS

#1. NAME: _____

ADDRESS: _____

TELEPHONE: _____

CELLPHONE/PAGER: _____

EMAIL: _____

RELATIONSHIP: _____

#2. NAME: _____

ADDRESS: _____

TELEPHONE: _____

CELLPHONE/PAGER: _____

EMAIL: _____

RELATIONSHIP: _____

PHOTO

Attach photo here

PATIENT HISTORY

#1. IDENTIFYING SCARS / DEFORMITIES: _____

MEDICATION BEING TAKEN: _____

FOR: _____

ADDITIONAL PHYSICAL PROBLEMS: _____

#2. ATTENDING PHYSICIAN: _____

ADDRESS: _____ TELEPHONE: _____

HOSPITAL ASSOCIATED WITH: _____

ADDRESS: _____ TELEPHONE: _____

#3. DOES PATIENT ATTEND DAY CARE PROGRAM? YES NO

NAME OF PROGRAM: _____

ADDRESS: _____ TELEPHONE: _____

DOES PATIENT WANDER? YES NO

IF SO, IN ANY PARTICULAR DIRECTION OR LOCATION? _____

#4. DOES PATIENT DRIVE? YES NO

DO THEY HAVE ACCESS TO A CAR? YES NO

IF SO, REGISTRATION NUMBER: _____ STATE: _____

YEAR: _____ MAKE: _____ MODEL: _____

