Belmont Police Department
Special Needs Alert Form

This form was created to assist the BPD in looking for citizens who go missing due to medical or behavioral situations.

Please include as much information as possible. NO DETAIL IS TOO SMALL!

These forms are kept in a separate file and only taken out when the person is reported missing, and the family member informs the dispatcher that a form has been filled out.

If possible please e-mail a picture of your family member to the department instead of attaching one to the form. Digital photos allow for rapid distribution to our officers and the surrounding towns.

Photos should be mailed to Dispatch Supervisor Tom O'Brien at tobrien@belmontpd.org

Please don't wait to call us when your family member goes missing! It is our job to help you! You are not "bothering us"!

After the form is turned into the BPD please notify us of any changes and send us updated pictures when possible (especially for young family members)

To report a family member missing call 911

For questions concerning this form call 617-484-1212 and ask for either Supervisor O'Brien or Lt. Kristin Daley

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:_____

CELLPHONE #:_____ CELL CARRIER_____

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:_____

#5. DOES PATIENT USUALLY CARRY IDENTIFICATION? YES NO

#6. CAN PATIENT BE PHYSICALLY OR VERBALLY ABUSIVE? YES NO

IF YES, PLEASE BE SPECIFIC:_____

_____

_____

#7. PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS REGARDING THIS PERSON, THEIR HABITS OR PAST BEHAVIOR, THAT MAY ASSIST RESPONDING AGENCIES, IN THE SPACES BELOW:

_____

_____

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