



## ***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](mailto: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: \_\_\_\_\_

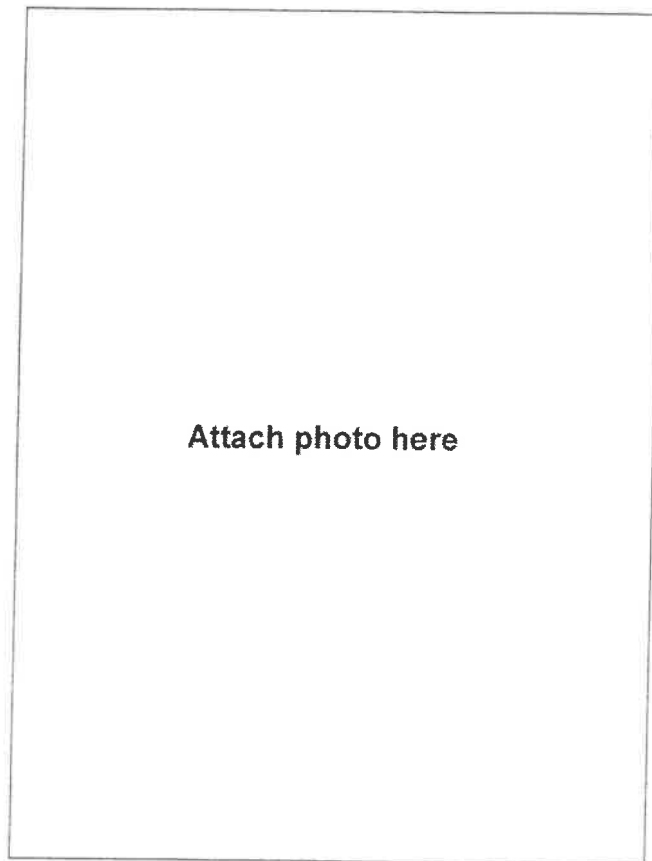
TELEPHONE: \_\_\_\_\_

CELLPHONE/PAGER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

## PHOTO



# 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: \_\_\_\_\_

