PROJECT LIFESAVER & Stony Point Police Dept.

Enrollment Application / Client Profile

This **Project Lifesaver** application is designed for Custodial Caregivers. By Submitting this application, you will be considered for participation in the **Project Lifesaver Program**. Please print this application and bring it to the Stony Point Police Department 79 RT 210 Stony Point, NY 10980.

This application should be filled out by a **FAMILY MEMBER, FRIEND, CAREGIVER or GUARDIAN** on behalf of the client, who will be enrolled in the **Project Lifesaver Program**. You may be sent additional materials to complete.

Client's Name: _____

(Individual for whom this application is being made)

Client's Diagnosis: _____

Transmitter Frequency: _____ Tests at: _____

Date Transmitter Placed: _____

Unit Member completing form: _____

Client's Photo:

(Attach here)

Client Data

Name: _____ Nickname: _____

Address: _____ Telephone: _____

_____

How long has the client been living at this address? _____

Client's Former Addresses:

_____ _____

_____ _____

CLIENT DESCRIPTION

Date of Birth: _____ Current Age: _____ Gender: M ___ F ___

Height: _____ Weight: _____ Build: _____ Race: _____

Hair Color: _____ Hair Style: _____ Eye Color: _____

Complexion (circle): Fair Medium Dark

Does the client wear: Glasses Contacts Hearing Aids

If "yes," are they worn full –time?

Explain _____

Circle all that apply: Beard Moustache Bald Wig Cane Walker Limp

COMMENTS: _____

_____

Other distinguishing physical characteristics (birth mark, mole, scar, tattoo, etc.):

_____

_____

_____

Is the client's primary language English? Yes No

If "No," what language? _____

CLIENT INFORMATION

Client's verbal/non-verbal skills (circle): None Poor Fair Good
Explain: _____

_____

If verbal, can the client communication his/her name, address, phone number, etc.? Yes No
Explain: _____

_____

Does the client us an augmentative communication device? Yes No
If "Yes," what device, and how proficient is the client in communicating with others:
Explain: _____

_____

Client's likes, dislikes and pre-occupations: _____

_____

_____

List articles/items normally carried by client: _____

_____

Is the client familiar with the area? Yes No How recent (months/years): _____
If, "No," what area(s) are known/familiar to the client? _____

_____

MEDICAL/PSYCHOLOGICAL INFORMATION

Does the client have any known medical problems? Yes No
Explain: _____

_____

_____

_____

Does the client have any known psychological problems? Yes No
Explain: _____

_____

_____

(Attach additional pages if necessary)

Current Medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach additional pages if necessary)

Client's Primary Care Physician: _____

Address: _____ Telephone: _____

_____

WANDERING HISTORY

Is there any prior history of the client becoming "lost or wandering?" Yes No

If "Yes," describe the event(s) in detail with dates: _____

_____

_____

_____

_____

Location found: _____

By whom: _____

Actions taken: _____

(Attach additional pages if necessary)

Were law enforcement authorities notified or involved? Yes No

Explain: _____

_____

_____

HABITS/PERSONALITY

Does the client smoke? Yes No Comments: _____

Does the client use alcohol? Yes No How often/type? _____

Does the client use (illicit) drugs? Yes No Type? _____

Does the client have access to any weapons (guns etc.) _____

Does the client have fears (dogs, cats, people, noises, darkness, etc.)? _____

_____

Will the client talk to strangers? _____

Is the client a danger to self or others? _____

List the client's hobbies/interests: _____

Is there any additional information you would like to provide regarding the client? _____

_____

_____

_____

(Attach additional pages if necessary)

FAMILY MEMBER/FRIEND/CAREGIVER INFORMATION

Name: _____

Relationship to Client: _____

Address: _____ Home Telephone: _____

_____ Cell Phone: _____

_____ Work Phone: _____

Email: _____ Fax: _____

Name of Employer: _____

Employer's Address: _____ Employer's Phone: _____

_____

_____ _____

Signature of Unit Member **Date**