alzheimer
SOCIETY OF WASHINGTON

Project Lifesaver - Personal Data Questionnaire

Office use only
Client Name: _____

Transmitter Activation Date: _____ Frequency Number:_____

Bracelet Location: ☐ Wrist ☐ Ankle

This application is designed for Caregivers to provide, in advance, certain information that will be useful to teams that may have to search for the person that will be wearing the transmitter bracelet. Providing accurate, detailed information will allow us to do our job faster and more efficiently.

Caregiver Contact Information

Caregiver Name: _____

Address: _____State: _____ Zip: _____

Telephone: _____ Other Phone: __ _____

Email: _____

Participant Personal Data

Name: _____ Maiden Name: _____

Preferred Name (or goes by):_____

Address: _____State: _____ Zip: _____

Birthdate: ____-____-_____ (month-day-year) Age: _____ ☐Male ☐Female

Ethnic Background: _____

Level of Education:_____ Drives? ☐Yes ☐No

Relationship to Caregiver: ☐Spouse ☐Adult Child ☐Other: _____

Most recent previous address: _____

Most recent place of work: _____

Most recent occupation: _____

Current or recent community programs (adult day care, school, etc): _____

alzheimer
SOCIETY OF WASHINGTON

Physical Description

Height : _____ Weight: _____ Build: _____ Posture: _____

Complexion: _____ Eye Color: _____

Face Shape: ☐Round ☐Square ☐Oval ☐Other: _____

Hair Color:_____ Hair Style: _____

Balding? ☐Yes ☐No Mustache? ☐Yes ☐No Beard? ☐Yes ☐No

Sideburns? ☐Yes ☐No False Teeth? ☐Yes ☐No

Marks/Scars/Tattoos (location & description):_____

_____

Hearing Aid? ☐Yes ☐No (Degree of hearing without aid) ☐None ☐Poor ☐Fair

Glasses? ☐Yes ☐No (Type or style)

Sunglasses? ☐Yes ☐No

Contact Lenses? ☐Yes ☐No (Degree of vision without eyewear) ☐Poor ☐Fair

Assistance walking? ☐Yes ☐No *If yes*: ☐Cane ☐Walker ☐Wheelchair ☐Other:_____

_____

Personal Articles Normally With the Participant

Jewelry? ☐Yes ☐ No Describe:

Watch? ☐Yes ☐No Type: Color:

Tobacco Products? ☐Yes ☐No Type: Brand:

Matches? ☐Yes ☐No Lighter? ☐Yes ☐No

Candy/Gum? ☐Yes ☐No Type:

Food Items? ☐Yes ☐No Explain:

Other Pocket or Purse Items? _____

_____

alzheimer
SOCIETY OF WASHINGTON

Personality / Habits

Smoker? ☐Yes ☐No What Type?

Drinks Alcohol? ☐Yes ☐No What Type? How much?

Uses Illicit Drugs? ☐Yes ☐No What Type? How often?

Hobbies/Interests: _____

_____

_____

Circle One: Outgoing / Quiet Likes Groups / Being Alone A Follower / A Leader

How does the Participant respond to being physically hurt? (Cry, Shout, Hide, Bite, Hit, Strike-out, Soldier on, Touch injured area, Other)

_____

_____

Personality / Habits

☐Yes ☐No Participant talks to strangers.

☐Yes ☐No Talks to Police Officers or Firefighters.

☐Yes ☐No Participant walks regularly in their neighborhood. ☐Alone ☐w/Caregiver ☐Both

Which streets / intersections: _____

_____

_____

☐Yes ☐No Usually stays on established trails or walkways.

Where (if different than above): _____

_____

_____

☐Yes ☐No Will cross streets alone.

☐Yes ☐No Understands traffic (street lights, signals, etc.)

☐Yes ☐No Is able to use public transportation? Type:

☐Yes ☐No Does the Participant carry money or credit cards?

Explain how they access it, what they might buy: _____

_____

_____

☐Yes ☐No Does the Participant have access to firearms, knives, scissors, or instruments that could be used to hurt themselves or others?

Explain: _____

_____

_____

☐Yes ☐No Does the Participant normally carry a firearm or knife?

Explain: _____

_____

_____

☐Yes ☐No Does the Participant have a history of trying to hide or avoid being found?

☐Yes ☐No Participant sleeps often and anywhere during the day.

Where have you found the participant sleeping in the past? _____

_____

_____

Health / Psychological Condition

Attending Physician:_____ Phone: _____

☐Yes ☐No Is the Participant dangerous to him/herself or others?

Explain:_____

_____

_____

☐Yes ☐No Any known physical handicaps?

What type? _____

_____

_____

☐Yes ☐No Allergies/sensitivities?

What type? _____

_____

_____

☐Yes ☐No Medical or memory loss problems?

☐Heart ☐Diabetic ☐Seizures ☐Dementia ☐Other:

Additional Information? _____

_____

_____

☐Yes ☐No Has the Participant been diagnosed with dementia or memory loss, hearing problem, vision problem, Down syndrome, autism, head injury, or other?

Prescription Medications

☐Yes ☐No Prescribed medications? If yes, list here or attach a photocopy:

Medication	Reason	Dosage & Frequency

☐Yes ☐No Physical or mental consequences of missing medication?

Describe: _____

_____

_____

☐Yes ☐No Psychological problems?

Describe: _____

_____

_____

Family / Friend Information

Which family member is the Participant closest to? _____

Type of relationship (sister, brother, aunt, etc): _____

Contact information: _____

Other persons (family or friends) the Participant may attempt to contact:

Name: Address:	Phone:
Name: Address:	Phone:
Name: Address:	Phone:
Name: Address:	Phone:

☐Yes ☐No Are there family members or acquaintances that would knowingly or unknowingly assist the Participant in leaving the area?

Explain: _____

_____

_____

Life Experience

What person, place or thing does the Participant currently value above anything else?

_____

_____

_____

Knowledge of local area: ☐None ☐Poor ☐Fair ☐Good ☐Excellent

Other areas known to the Participant: _____

_____

_____

☐Yes ☐No Taken first aid training? ☐Yes ☐No Involved in scouting?

☐Yes ☐No Swims? ☐Yes ☐No Afraid of water?

☐Yes ☐No Military experience? Where When

☐Yes ☐No Outdoor recreational experience? Explain:

☐Yes ☐No Been lost before?

Explain: _____

_____

_____

☐Yes ☐No Been in trouble with the law?

Explain: _____

_____

_____

☐Yes ☐No Is the Participant a religious person?
Place of worship: Pastor:

Dementia Diagnosis Information

☐Yes ☐No Participant is visually impaired.

☐Yes ☐No Participant has stooped posture and shuffling walk.

☐Yes ☐No Participant can feed and hydrate themself.

☐Yes ☐No Participant may exhibit extreme thirst.

☐Yes ☐No Participant could be incontinent.

☐Yes ☐No Participant can distinguish between day and night.

☐Yes ☐No Participant can distinguish between the seasons of the year.

☐Yes ☐No Participant is oriented to the time, place, and self.

Explain: _____

_____

_____

☐Yes ☐No Participant travels to familiar locations.

Where / How? _____

_____

_____

☐Yes ☐No Participant has awareness of current circumstances.

Explain: _____

_____

_____

☐Yes ☐No Participant recognizes familiar persons and faces.

Explain: _____

_____

_____

☐Yes ☐No Participant tends to re-live events in their past.

Explain: _____

_____

_____

☐Yes ☐No Participant has irregular and frequently changing sleep patterns.

Explain: _____

_____

_____

☐Yes ☐No Participant suffers from frequent personality and emotional changes.

Explain: _____

_____

_____

☐Yes ☐No Known events or circumstances can trigger their wandering.

Explain: _____

_____

_____

☐Yes ☐No Participant is comfortable around dogs.

☐Yes ☐No Participant could be frightened or agitated by uniforms.

Explain: _____

_____

_____

Participant's ability to communicate verbally is ☐None ☐Poor ☐Fair ☐Good ☐Excellent

Contact Information

Please list those who you would like us to contact if there are any questions regarding the Participant or an emergency situation were to arise.

Primary Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Secondary Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____

Additional Contact: _____

Relationship to Participant: _____

Phone Number(s): _____

Email: _____

Address: _____