PROJECT LIFESAVER - TIPPECANOE COUNTY SHERIFF'S DEPARTMENT

Program Application & Personal Data Questionnaire

This form is designed to provide information on a Client that will be useful to Project Lifesaver team members and, should the need arise, searchers. Providing the information in advance of the need will give team members the necessary information to provide a more effective response should a Client become lost or missing.

Client Information:

Client Name: _____

Address: _____

City/State: _____ ZIP:_____

Phone: _____

Birth date: _____ Mental Capacity Age: _____ Sex: Male ○ Female ○ Ethnicity: _____

Diagnosis:_____

Nickname(s): _____

Most recent place of employment: _____

Most recent occupation: _____

Name of Spouse: _____ Living ○ deceased ○

Caregiver Information:

Caregiver Name: _____

Home Address:_____

City/State: _____ZIP: _____ Home Phone:_____

Work Address:_____

City/State:_____ ZIP:_____ Work Phone:_____

Cell Phone: _____ Email: _____

Revised 7/29/13

Client/Caregiver Preliminary Questions:

Does the client presently operate a motor vehicle? Yes ○ No ○

Is the client continually supervised, twenty-four hours a day, seven days a week? Yes ○ No ○

Does the client attend school or other supervised care program outside the home? Yes ○ No ○

If yes, please complete the following:

School/Program Name: _____

Facility Address: _____

Phone:_____ How long have they attended: _____

Hours: _____

Teachers Name:_____ Teacher E-Mail:_____

How is the client transported? _____

Will the client be willing to wear the transmitter on wrist at all times? Yes ○ No ○

If no, will the client be willing to wear the transmitter around an ankle at all times? Yes ○ No ○

Does the client have a history of aggressive or violent behavior? Yes ○ No ○

Are you, as the caregiver, willing to abide by the requirements of the program? Yes ○ No ○

Are "temporary caregivers" outside the home, willing to abide by the program requirements? Yes ○ No ○

Family/Friend Information

Other persons the client may contact (family, friends, etc.)

Name: _____ Phone: H ○ W ○ _____

Cell Phone_____ Email _____

Address_____City_____ Postal Code _____

Name: _____ Phone: H ○ W ○ _____

Cell Phone_____ Email _____

Address_____City_____ Postal Code _____

Client Description

Height: _____ ft., _____ in. Weight: _____ lbs. Build: thin ○ muscular ○ heavy ○

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

Complexion: light ○ dark ○ medium Beard: Yes ○ No ○ Sideburns: Yes ○ No ○

Mustache: Yes ○ No ○ Balding: Yes ○ No ○ False Teeth: Yes ○ No ○

Shape of Facial Features: Round/Square/Oval/Other: _____

Distinguishing Marks, Scars, Tattoos, etc. (describe): _____

Is the Client able to communicate? Check all that apply: Speak ○ Write ○ Sign ○ Mute ○ Deaf ○ Other? ○

Explain: _____

Client's level of comprehension: _____

If Client does not understand English, what language is understood? _____

Is the Client able to read? Yes ○ No ○ Reading Level: _____

Does the Client wear Glasses? Yes ○ No ○ Contacts? Yes ○ No ○ Sunglasses? Yes ○ No ○

What degree of vision does the Client have without eyewear? None ○ Poor ○ Fair ○ Good ○

Does the Client wear a hearing aid? Yes ○ No ○ If so, what style? _____

What degree of hearing does the Client have without an Aid? None ○ Poor ○ Fair ○ Good ○

Health/Psychological Condition

List all Medical Conditions:

Medical Condition 1:_____

Explanation of Medical Condition 1:_____

Medical Condition 2:_____

Explanation of Medical Condition 2:_____

Medical Condition 3:_____

Explanation of Medical Condition 3:_____

List all Psychological Conditions:

Psychological Condition 1:_____

Explanation of Psychological Condition 1:_____

Psychological Condition 2:_____

Explanation of C Condition 2:_____

Psychological Condition 3:_____

Explanation of Psychological Condition 3:_____

List all Medications:

Drug 1: _____ Drug 4: _____

Drug 2: _____ Drug 5: _____

Drug 3: _____ Drug 6: _____

Attending Physician: _____ Phone: _____

Does Client have any mobility problems? Yes ○ No ○ If Yes, what problems: _____

_____

Does Client use a cane or any other mobility assistance? Yes ○ No (circle) ○

Explain: _____

If Alzheimer's disease has been diagnosed, answer the following: (if not skip to page 6)

When was the Client diagnosed? _____

Does the Client remain oriented to Time and Person? Yes ○ No ○

Explain: _____

Does the Client recognize familiar persons and faces? Yes ○ No ○

Explain: _____

Can the Client travel to familiar locations? Yes ○ No ○

Explain: _____

Does the Client have decreased knowledge of current events or tend to re-live past events? Yes ○ No ○

Explain: _____

Does the Client sometimes dress improperly? Yes ○ No ○

Explain: _____

How well does the Client communicate? None ○ Poor ○ Fair ○ Good ○ Excellent ○

Is the Client Verbal? Yes ○ No ○

Does the Client respond to his/her own name? Yes ○ No ○

Explain: _____

Does the Client remember his/her own name and the names of spouse and/or children? Yes ○ No ○

Explain: _____

Are the Client's sleep patterns frequently altered? Yes ○ No ○

Explain: _____

Does the Client suffer from frequent personality and emotional changes? Yes ○ No ○
Explain: _____

Does the Client suffer from delusions (See imaginary visitors, talk to her/her own reflections in the mirror, imagine that their spouse in an imposter, etc)? Yes ○ No ○

Explain: _____

Does the Client wear a medical ID bracelet or other device to identify disability? Yes ○ No ○

Does the client have difficulty judging personal space? Yes ○ No ○

Through experience, is there a "most effective" way to approach the Client? Yes ○ No ○

If yes, please explain: _____

What preventative measures have been taken in the home to prevent the Client from wandering?

_____

_____

If Autism has been diagnosed, answer the following: (if not skip to page 7)

When was the Client diagnosed? _____

Does the Client sometimes dress improperly? Yes ○ No ○

Explain: _____

Does the Client know/respond to his/her own name? Yes ○ No ○

Explain: _____

Is the Client verbal? Yes ○ No ○ How well does the Client communicate? None ○ Poor ○ Fair ○ Good ○ Excellent ○

What is the best way to communicate with the Client? _____

Are the Client's sleep patterns frequently altered? Yes ○ No ○

Explain: _____

Does the Client suffer from frequent personality and emotional changes? Yes ○ No ○

Explain: _____

Personal Articles and/or Food Items Normally Carried by the Client:_____

_____

Where does the Client carry identification information? _____

Does the Client wear a medical ID bracelet or other device to identify disability? Yes ○ No ○
Does the Client have unusual reactions to sensory environment (touch, sound, bright lights, odors, and animals)?
Yes ○ No ○

If yes, please explain: _____

Is the Client insensitive to pain? Yes ○ No ○ Does the Client have trouble with direct eye contact? Yes ○ No ○

Does the Client dart away from you unexpectedly (bolt and run)? Yes ○ No ○

Does the client react differently to foods? Yes ○ No ○

If yes, what foods does the client react well to? _____
What foods does the client react adversely to? _____

Does the client have difficulty judging personal space? Yes ○ No ○

Through experience, is there a "most effective" way to approach the Client? Yes ○ No ○

If yes, please explain: _____

What preventative measures have been taken in the home to prevent the Client from wandering?
_____

_____

Experience

Is the Client familiar with the area? Yes ○ No ○ Length of residence? _____

If not local, what other areas are known to the Client? _____

Ever been lost before? Yes ○ No ○ Where/When: _____

Was Client found or walked out on own? _____

Location found: _____

Actions taken: _____

Personality/Habits

Hobbies/Interests: _____

Does the Client swim or participate in water based activities? Yes ○ No ○ Explain: _____

Is Client outgoing or Reserved (likes groups or being alone)? Outgoing ○ Reserved ○ Neither Extreme ○

Does the Client show evidence of Leadership? Yes ○ No ○ Explain: _____

_____

Does the Client have access to a vehicle? Yes ○ No ○ If so, please describe it completely: _____

_____

Is the Client **DANGEROUS** to themselves or others? Yes ○ No ○ Themselves ○ Others ○

Explain: _____

If the Client becomes anxious or agitated what is the best way to calm them? _____

_____

What other information do you feel needs to be shared concerning the Client? _____

_____

Return application to:

Tippecanoe County Sheriff's Department
ATTN: Project Lifesaver Coordinator/Sgt. Brian Lowe
2640 Duncan Road
Lafayette, IN 47904

To be completed by The Project Lifesaver Tippecanoe County Coordinator or Agency Administrator

Date Application Received: _____

Date of Scheduled Home Visit: _____

Name of Project Lifesaver Personnel Reviewing Application: _____

Click Here to Print Application