

# Project Lifesaver Application

Colonial Heights Police Department

This form is designed for Custodial Care Givers to provide certain information that will help determine if a client is eligible to participate in the Project Lifesaver Program. This form will also be used to provide necessary information to search teams and/or media should the need arise to establish a more effective search response.

Client's Name:		Age:	Client #:		
Date of Birth:	SSN:	Ht:	Wt:	Eyes:	Hair:
Beard: Yes / No	Hair Style:	Sideburns: Yes / No	Mustache: Yes / No		
Balding: Yes / No	False Teeth: Yes / No	Nicknames:			
Address:					
City:		State:	Zip Code:		
Phone Number:		Cell Phone:			

The following information applies to our policies concerning admittance into Project Lifesaver:

1. Live within the city limits of Colonial Heights, Virginia.
2. Be diagnosed as having Alzheimer's disease, other dementia disorders, autism, Down's syndrome or similar disorder.
3. Be known to wander away from caregivers.

Does the client speak English? Yes / No	If no, what language:
Does the client wear a hearing aid? Yes / No	If yes, what type of hearing w/out aid? None/Poor/Fair
Does the client have vision problems? Yes / No	If yes, what type of vision w/out glasses? None/Poor/Fair
What is the client's cognitive disability?	
Does the client have any known physical handicaps?	
Does the client have any known medical problems?	
List any medication the client is currently taking (correct name of drug & dosage):	

Consequences of *not* taking medications:

## Client Behavior

1. Has the client ever wandered or become lost before? Yes / No      If yes, answer the following:

a. When? (Month / Year):

b. Where were they found and by who?

c. Was law enforcement called? Yes / No      If yes, what agency?

2. Is the client allowed to drive or do they have access to a vehicle? Yes / No      If yes, answer the following

a. Make of vehicle:

d. License Plate of vehicle:

b. Model of vehicle:

e. State of issue:

c. Color of vehicle:

3. Does the client have a bus pass or frequently ride the public transit system? Yes / No

4. Does the client remain oriented to current date & time? Yes / No      If no, explain:

5. Does the client recognize familiar persons and faces? Yes / No      If no, explain:

6. Can the client travel to familiar locations? Yes / No      If yes, explain:

7. Does the client have knowledge of current events or do they tend to relive events in their life? Yes / No

Explain:

8. Can the client clothe themselves properly? Yes / No      If no, explain:

9. Does the client remember their own name and the names of spouse and/or children? Yes / No

Explain:

10. Does the client suffer from frequent personality and emotional changes? Yes / No

Explain:

11. Does the client suffer from delusions? (Example: Sees imaginary visitors, talks to their own reflection in the mirror, imagine that their spouse is an imposter, etc) Yes / No      If yes, explain:

12. How good is the client's communication ability? None / Poor / Fair / Good / Excellent

13. Does the client need the use of a can, walker or wheelchair? Yes / No      If yes, explain:

14. Is the client familiar with Colonial Heights? Yes / No      Explain:

a. How long have they lived here?

b. If not from Colonial Heights, what other areas are they familiar with?

15. Will the client talk to strangers? Yes / No      Explain:

16. Is the client dangerous to themselves or others? Yes / No      If yes, explain:

# Family / Caregiver Information

Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:
Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:
Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:
Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:
Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:
Name:		
Relationship to Client:		
Address (if different from client):		
Home Phone:	Work Phone:	Cell Phone:

I affirm that the information is true and accurate to the best of my knowledge. I understand that providing false and/or inaccurate information may result in a denial of the applicant's acceptance into Project Lifesaver. I also understand that the Colonial Heights Police Department is requesting a digital photograph of the client that will only be used if the client wanders away and a search is initiated.

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Caregiver's Signature

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Caregiver's Printed Name

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Date