Project Lifesaver Ohio

Confidential Client Profile

Transmitter Frequency Is: _____

Issue Date: _____

Name of Person Wearing Transmitter: _____

Current Address: _____ Years at address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Client Personal Data

Date of Birth: _____ Age: _____ Race: _____

Physical Handicaps: _____

Known Medical Problems: _____

Regular Medications: _____

Consequences of ***NOT*** Taking Medications: _____

Attending Physician: _____ Phone: _____

Previous Address: _____ Years at Address: _____

Most Recent Occupation: _____ Location: _____

Prior Occupation: _____ Location: _____

Other Places the Client Spends Time: _____

_____

_____

_____

Client Physical Description

Height: _____ ft _____ in Weight: _____ Build: _____

Hair Color: _____ Eye Color: _____ Complexion: _____

Facial Hair(Describe): _____

Distinguishing Marks(scars, marks, and tattoos): _____

Eye Glasses: Yes / No

General Appearance: _____

Does Client Use Cane, Walker, etc...: _____

Jewelry worn (Describe): _____

Does Client carry Wallet / Purse (Circle One) Average Amount of Money: _____

Use Tobacco Products: _____ If so, What Brand: _____

Other Personal Items Carried: _____

Hobbies and Interests: _____

What Does Client ***Always*** Take With Them if Going Out: _____

Client a Danger to Himself/Herself: _____ Talk to Strangers: _____

Will Client Respond if Name is Called Out: _____

Does Client Drive: _____ Own a Car: _____ Make: _____ Model: _____

Color: _____ License Plate: _____ Other: _____

Has Client Ever Been Lost Before: _____ When: _____

Were Police Called: _____ Where was Client Located: _____

Elapsed Time From Discovery to Recovery: _____

Name of Spouse: _____ Living / Deceased: _____

Address of Spouse: _____

Primary Caregiver: _____

Address: _____

City: _____ State: _____ Phone: _____

Children / Friends of Client

Name	City/State	Phone	Relationship

Is Client Time and Person Oriented: Yes No

Does Client Recognize Familiar Faces: Yes No

Does Client Have Knowledge of Current Events: Yes No

Can Client Walk to Familiar Locations Without Caregiver: Yes No

Does Client Spend Part of Any Day in Another's Care: Yes No

If So, Who and When: _____

Does Client Sometimes Clothe Himself Inappropriately: Yes No

Have Clients Sleeping Habits Changed Recently: Yes No

If So, Explain: _____

How Good are Clients Communications Skills: Fair Poor

Comments: _____

Profile

Person Filling Out Form: _____

Day Phone: _____ Night Phone: _____