LYNCHBURG PROJECT LIFESAVER APPLICATION

Staff Use Only:
Frequency _____ Client Number _____

Search Management Section Personal Data Questionnaire

This form is designed for *Custodial Care Givers* to provide in advance, information that will be useful to Search Teams should the need arise. Providing the information in advance of the need will allow search management personnel to do their job faster.

Resident: _____

Address: _____

City/State: _____ Zip: _____

Primary Phone: _____Secondary Phone: _____

Resident's Personal Data

Birth date: _____ Sex: _____ Race: _____ SS# _____

Nickname(s): _____

Most Recent Address: _____

Most Recent Place of Work: _____

Most Recent Occupation: _____

Name of Spouse: _____ Living ☐ Deceased☐

Name of Parents: _____

Physical Description

Height: _____ ft _____ in. Weight _____lbs. Build _____
Hair Color/ Style _____Eye Color _____ Complexion _____

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., please describe _____

_____

General Appearance _____

If Resident does not understand English, what Language is understood?_____

Spoken word only YES ☐ NO ☐
Written word only YES ☐ NO ☐
Non Verbal YES ☐ NO ☐
Sign Language YES ☐ NO ☐

Does Resident wear: Glasses YES ☐ NO ☐ Contacts YES ☐ NO ☐ Sunglasses YES ☐ NO ☐
If yes to any of the above what Style: _____

If Resident wears glasses or corrective eyewear what degree of vision does he/she have without the eyewear?
None ☐ Poor ☐ Fair ☐

Does Resident wear a hearing aid? YES ☐ NO ☐
If yes, what style? _____
If yes, what type of hearing without aid? None ☐ Poor ☐ Fair ☐

Health/Psychological Condition

Diagnosed with: _____

Any known physical handicaps? YES ☐ NO ☐
Please describe: _____

_____

Any known medical problems? YES ☐ NO ☐
Please describe:_____

_____

Medications taken regularly? YES ☐ NO ☐
List any medication using correct name of drug and dosage being taken: _____

_____

_____

Consequences of **NOT** taking medications? _____

_____

_____

Attending Physician _____Telephone Number: (____)_____

Any psychological problems? YES ☐ NO ☐
Please describe:_____

_____

Personal Articles Normally Carried by the Resident

Tobacco Products: YES ☐ NO ☐ Type: _____ Brand: _____
Candy/Gum: YES ☐ NO ☐ Type: _____ Brand: _____
Matches: YES ☐ NO ☐ Type: _____ Brand: _____
Cell Phone: YES ☐ NO ☐ Type: _____ Phone #: _____

Food Items: _____

Facial tissue or other pocket/purse items: YES ☐ NO ☐ Describe: _____

Approximate amount of cash on hand: _____

Where cash normally carried:

Handbag? YES ☐ NO ☐ Purse? YES ☐ NO ☐ Wallet? YES ☐ NO ☐

Description _____ Type _____ Color _____

Description _____ Type _____ Color _____

Jewelry? YES ☐ NO ☐ Please describe: _____

Watch? YES ☐ NO ☐ Type: _____ Color: _____ Description: _____

Pocket watch? YES ☐ NO ☐ Wrist watch YES ☐ NO ☐

Other Items? YES NO Please describe: _____

Additional background information, please answer the following:

1. YES ☐ NO ☐ Does the Resident remain oriented to time and person?
   Explain: _____

2. YES ☐ NO ☐ Does the Resident recognize familiar persons and faces?
   Explain: _____

3. YES ☐ NO ☐ Can the Resident travel to familiar locations? If yes, where do they frequent the most?
   Explain: _____

4. YES ☐ NO ☐ Does the Resident have deceased knowledge of current events or tend to re-live events in his/her life?
   Explain: _____

5. YES ☐ NO ☐ Does the Resident sometimes clothe himself/herself improperly? (Example: Putting shoes on the wrong feet, adding underwear over clothing?
   Explain: _____

6. YES ☐ NO ☐ Does the Resident remember his/her own name and the names of parents, spouse, siblings, and or children?
   Explain: _____

7. YES ☐ NO ☐ Do the Resident's sleep patterns occur at regular intervals?
   Explain: _____

8. YES ☐ NO ☐ Does the Resident suffer from frequent personality and emotional changes?
   Explain: _____

9. YES ☐ NO ☐ Does the Resident suffer from delusions (see imaginary visitors, talk to his/her own reflection in the mirror, imagine that their spouse is an imposter, etc?)
   Explain: _____

10. YES ☐ NO ☐ Can the Resident communicate with others?
    Explain: _____

11. YES ☐ NO ☐ Do they travel? If yes, explain mode of transportation (foot, bus, car, cab, etc.)
    EXPLAIN _____

Care Giver/Billing Information

Name of person filling out this form: _____

Facility/Organization (if any): _____

Address: _____

City/State: _____ Zip: _____

Primary Phone: _____ Business Phone: _____

Email Address: _____

Billing address: (if different from above)

Name of person filling out this form: _____

Address: _____

City/State: _____ Zip: _____

Primary Phone: _____ Business Phone: _____

Email Address: _____

Family/Friend Information

Other persons the resident may contact (family, friends, etc)

Name: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Business Phone: _____

Name: _____

Primary Phone: _____ Secondary Phone: _____

Business Phone: _____

Address: _____

Name: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Business Phone: _____

Name: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Business Phone: _____

Additional information we should know about the resident: _____

_____

_____

_____

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_____

Please read:

I hereby certify that the above information is true and accurate to the best of my knowledge and that I have been thoroughly briefed by a member of Lynchburg Project Lifesaver. I understand that the duties of Project Lifesaver personnel are:

- to inspect Project Lifesaver equipment
- to provide a 30 or 60 day maintenance/log sheet;
- to replace equipment if needed;
- to search for the patient when lost.

I also understand that the equipment being used is the property of Lynchburg Project Lifesaver and upon termination of the service, all equipment is to be returned to Lynchburg Project Lifesaver.

Signature

Care Giver _____

Date _____

Staff Use Only

Approved _____

Date transmitter put in operation: _____

Frequency _____

Client Number: _____