PROJECT LIFESAVER CLIENT FILE

This document is for both children and adults. Please fill out any and all information that is applicable to the person / client who will be enrolled.

This form is designed for Custodial Care Givers to provide, in advance, certain 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 the necessary information to establish a more effective search response. All questions highlighted in RED are required.

Client's Personal Data: (Write n/a if the question isn't applicable to the client)

Birthdate: Sex: ◯ Male ◯ Female Race:

Name: Nickname:

Most recent address:

School Name: Address:

Teacher's Name: Phone Number:

Name of Spouse: Spouse is: ☐ Living ☐ Deceased

Most recent occupation: Most recent place of work:

Does Client speak? ◯ Yes ◯ No

Communicates both Written and Spoken? ◯ Yes ◯ No Spoken word only? ◯ Yes ◯ No

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

Attending Physician / Pediatrician Name & Address:

Attending Physician / Pediatrician Phone Number:

Diagnosis: (Select all that apply)

- Dementia
- Alzheimer's Disease
- Autism
- Other Cognitive Impair

Other Cognitive Impairment (Explain):

Has Client ever wandered before? ◯ YES ◯ NO

Where were they when they wandered:

When / Time of Day (Mark all that apply): ☐ Morning ☐ Afternoon ☐ Evening

Located by searchers or returned by himself/herself? ☐ Located ☐ Returned by Themselve

Location(s) found:

Safety Actions taken:

Is the Client DANGEROUS to himself/herself or others? ◯ YES ◯ NO

If yes, Explain:

Does the Client become upset easily? ◯ YES ◯ NO

What tends to calm them?

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Client's Personal Information: **(*Write n/a if the question isn't applicable to the client)***

1. What reaction does Client have if injured?(Cry,shout,etc.)
2. Will Client talk to strangers? ◯ YES ◯ NO
3. How might the person react to sirens, helicopters, airplanes, search dogs, people in uniform, or those participating in a search team?
4. Is the Client attracted to water? ◯ Yes ◯ No 5. Can they swim? ◯ Yes ◯ No
6. How good is the Client's communication ability? ◯ None ◯ Poor ◯ Fair ◯ Good ◯ Excellent

Personal Articles Normally Carried by the Client:

7. Tobacco Products: ◯ YES ◯ NO If yes, Brand:
8. Candy/Gum: ◯ YES ◯ NO If yes, Brand:
9. Matches: ◯ YES ◯ NO 10. Lighter: ◯ YES ◯ NO
11. Purse or Wallet ◯ YES ◯ NO Please describe:
12. Jewelry / Watch ◯ YES ◯ NO Please describe:
13. Other (describe):

Equipment:

14. ☐ Cane ☐ Walker ☐ Other (describe):

Experience:

15. Familiar with area? ◯ YES ◯ NO
    If not local, what other areas are known to Client?
16. Does the Client ever go out alone? ◯ YES ◯ NO
17. Has the Client ever taken first-aid training? ◯ YES ◯ NO
18. Was the client ever involved in Scouting? ◯ YES ◯ NO
19. Does the Client have military experience? ◯ YES ◯ NO
    If yes, job duty in Military:

Personality / Habits:

20. Smoke? ◯ YES ◯ NO If yes, Brand: 21. Drink Alcohol? ◯ YES ◯ NO
22. Hobbies/Interests:

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Client's Personal Information:

23. Where was Client born and raised? (city,state)

24. Religious? ◯ YES ◯ NO

What faith?

25. What does Client value most (ex: favorite toy / trinket,person, etc.)?

26. Which family member is Client closest to?
Relationship:

27. Client a Member of any Organization: (Example: Church, Amvets, AARP, DD) ◯ Yes ◯ No

If yes, explain:

28. Does the Client remain oriented to Time and Person? ◯ YES ◯ NO

29. Does the Client recognize familiar persons and faces? ◯ YES ◯ NO

30. Can the Client travel to familiar locations? ◯ YES ◯ NO

Explain:

31. Does the Client have decreased knowledge of current events or tend to re-live events in his/her life?
◯ YES ◯ NO If yes, describe:

32. Does the Client sometimes clothe himself/herself improperly? ◯ YES ◯ NO
(Example: Putting shoes on the wrong feet, adding underwear over clothing?)

33. Does the Client remember his/her own name and the names of spouse and or children? ◯ YES ◯ NO

34. What is the Client's sleep pattern?

35. Does the Client suffer from frequent personality and emotional changes? ◯ YES ◯ NO
Explain:

36. Does the Client suffer from delusions? ◯ YES ◯ NO
(Ex: See imaginary visitors, Talk to his/her own reflection in the mirror, Imagine that their spouse is an imposter, etc?)

If yes, explain:

37. Does the Client have a valid driver's license? ◯ YES ◯ NO

38. Does the Client have access to a vehicle?* ◯ YES ◯ NO

If yes, (Make, Model, Description):

***Client should not have access to a vehicle or keys to family vehicles.**

***Client's Fears: (Check all that apply)*:**

☐ Dogs ☐ People ☐ Noises ☐ The Dark

☐ Person in Uniform ☐ Other Describe:

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Client's Physical Description:

Height: 5 feet 7 inches

Weight: _____ pounds

Hair color: _____

Hair style: _____

Eye Color: _____

False Teeth? ◯ YES ◯ NO

Beard? ◯ YES ◯ NO

Mustache? ◯ YES ◯ NO

Balding? ◯ YES ◯ NO

Sideburns? ◯ YES ◯ NO

Distinguishing marks, scars, tattoos, etc. ? ◯ YES ◯ NO

Describe: _____

Does Client wear glasses? ◯ YES ◯ NO **Contacts?** ◯ YES ◯ NO

If Client wears glasses or corrective eyewear, what degree of vision does he/she have without the eyewear: ◯ None ◯ Poor ◯ Fair

Does Client wear a hearing aid? ◯ YES ◯ NO

If yes, what type of hearing without aid? ◯ None ◯ Poor ◯ Fair

Health/Psychological / Sensory Condition:

Any known physical handicaps? ◯ YES ◯ NO
If Yes, describe: _____

Any known medical problems? ◯ YES ◯ NO
If Yes, describe: _____

List medication taken regularly using correct name of drug and dosage being taken:

_____

Consequences of NOT taking medications: _____

Any Psychological Issues: ◯ YES ◯ NO If yes, explain: _____

Sensory Issues? ◯ YES ◯ NO If yes, explain: _____

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Caregiver / Primary Contact Information:

Primary Contact Person Name:

Relationship to Client:

Full Address:

Home Phone:

Work Phone:

Other:

Email Address:

Please list two (2) additional contacts:

1.**Contact Person Name:**

Relationship to Client:

Full Address:

Home Phone: Work Phone: Other Phone:

2.**Contact Person Name:**

Relationship to Client:

Full Address:

Home Phone: Work Phone: Other Phone

Sheriff's Office Use Only

Date Transmitter Placed: _____ **Frequency #:** _____
Facility / Organization: Clark County Sheriff's Office
Address: 120 North Fountain Avenue, Springfield, Ohio 45502
Office Phone: 937-521-2050

Representative filling out this form: _____

PL Servicer that places transmitter on: _____

After you have completed the form, save a copy and email it to: wholt@clarkcountyohio.gov

Or you can mail your completed form to: Clark County Sheriff's Office
Attn: Wendy Holt
120 North Fountain Avenue
Springfield, Ohio 45502