At Risk Resident Registration

Client's Name: ____

Client's Address: ____

Primary Caregiver: ____

Relationship to Client: _____________________________________

Caregiver Address: ____

Caregiver Home Phone: ___________ Caregiver Cell Phone: ____________

Client Information

Date of birth: _________ Height: ________ Weight: ________

Eye color: _______Hair color: ______ Male _____Female__ Race: _______

Complexion (circle one): Fair Medium Dark

Circle the characteristics that apply:

Glasses Contacts Hearing Aid Wig Beard Mustache

Bald Cane Right-handed Left-handed Other: __________

Describe/Location:

Mole: __________ Tattoo: _________ Scar: ___________

Birthmark: ____________ Any handicap: ____________________

Client's Habits

Does client attend a Day Service Program? Yes No

If yes, where? _______________________________________

Phone number: ________ Does client wander? Yes No

If yes, in any particular direction/place? _______________________________

____

Individual habits: ____

____

Does client understand English? Yes No

If not, what is client's primary language? _________________________

Can client understand simple directions? Yes No

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Is client physically aggressive? Yes No

Is client verbally aggressive? Yes No

Does client still drive? Yes No

Does client have access to a car? Yes No

License plate number:____________ Make:___________Model:_________Year:____

Does client carry identification: Yes No What kind?_________________

Contact Information

Primary contact/Caregiver: called first if person is found

Name:____

Address:____

Telephone: Home:____________________ Work:____________________

Cell:_____________________ Other:___________________

Relationship to client:____

Additional Contacts: can be called if primary contact is not available.

Name:____

Address:____

Telephone: Home:____________________ Work:____________________

Cell:_____________________ Other:___________________

Relationship to client:____

Name:____

Address:____

Telephone: Home:____________________ Work:____________________

Cell:_____________________ Other:___________________

Relationship to client:____

Medical Information

Physician Name:____

Physician Telephone Number:_______________________________________

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Medical Conditions:____

____

Critical Medications:____

____

Other helpful comments/information:__________________________________

____

____

____

____

____

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Authorization

Contact Name:___________________________________

I, ____________________________________, authorize the use of this information with the Westerly Police Department and with other agencies where I receive services. I understand that this information will be filed and kept confidential to the extent of law and used only for purposes of identification and assistance related to the safe return efforts and related investigative activities. Authorization can be withdrawn at any time.

List of other agencies that provide me services:

____

____

____

Client Signature:____

Authorized Representative Signature:____________________________________

Date:_______________

Please Check One:

( ) Power of Attorney (POA)

( ) Durable Power of Attorney Healthcare (DPAHC)

( ) Guardian

( ) Client