

**GRANTHAM POLICE DEPARTMENT  
ALZHEIMER'S and INDIVIDUALS WITH SPECIAL NEEDS  
ASSISTANCE PROGRAM**

**Patient Information:** SSN: \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **MI:** \_\_\_\_\_

Address: # \_\_\_\_\_ Street: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Phone No.: \_\_\_\_\_

DOB: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Glasses: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair: \_\_\_\_\_ Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Body: \_\_\_\_\_ Face: \_\_\_\_\_

Speech: \_\_\_\_\_ Facial Hair: \_\_\_\_\_ Complexion: \_\_\_\_\_ Nose: \_\_\_\_\_ Handed: \_\_\_\_\_

Photo Taken: \_\_\_\_\_ Date of Photo: \_\_\_\_\_ Driver's License State \_\_\_\_\_ # \_\_\_\_\_

Vehicles(s): State: \_\_\_\_\_ Plate #: \_\_\_\_\_ State: \_\_\_\_\_ Plate #: \_\_\_\_\_

**Narrative:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Persons to Contact in Case of an Emergency:**

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Medical Information:**

Preferred Hospital: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

**CHECK IF A PHOTOGRAPH IS ATTACHED:**