York-Poquoson Project Lifesaver

York-Poquoson Sheriff's Office
P.O. Box 99
Yorktown, Virginia 23690

FREQUENCY 216.__________

SEARCH MANAGEMENT SECTION PERSONAL DATA QUESTIONNAIRE

This form is designed for *Custodial Caregivers* 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 to do their job faster, when needed.

CLIENT ____

Address: ____

City / State: __________________________________ Zip: __________________

Phone: ______________________________________

Email: ____

Social Media Platforms & Names Used: _______________________________________

Client's Personal Data

Birth Date: __________ Sex: ________ Race: _________ SS# _____________

Nickname(s): ____

Most Recent Address: ____

Most Recent Place of Employment: ____

Most Recent Occupation: ____

Name of Spouse: ______________________________ Living / Deceased (circle)

Other Areas that the client may frequently try to visit: _______________________________

____

____

Physical Description

Height: ____ ft., _____ in. Weight: ________lbs. Build: ________________________

Hair Color: ______________ Hair Style: _____________ Eye Color: ____________________

Complexion: _________________ Beard: Yes / No (circle) Sideburns: Yes / No (circle)

Mustache: Yes / No (circle) Balding: Yes / No (circle) False Teeth: Yes / No (circle)

Shape of facial features: Round / Square / Oval / Other _________________________________

Distinguishing Marks, Scars, Tattoos, etc. Describe: ___________________________________

____

General Appearance: ____

If client does NOT understand English, what Language is understood? __________________

Do they speak the language? Yes / No (circle) Can they write the language? Yes / No (circle)

Do they wear glasses? Yes / No (circle) Contacts? Yes / No (circle)

Sunglasses? Yes / No (circle)

If yes to any of the above, what style: ____

If the client wears glasses or corrective eyewear, what degree of vision does he / she have without the eyewear? None / Poor / Fair (circle one)

Personal Data Questionnaire

Does the client know how to swim? Yes / No (circle)

Does the client wear a hearing aid? Yes / No (circle)What style? ____________________

If yes, what type of hearing do they have without aid? None / Poor / Fair (circle one)

Health / Psychological Condition

Any known physical disabilities? (Please describe) ______________________________________

____

Any known medical problems? (Please describe) ____

____

Medications taken regularly? ____

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   Nature: ____________________________________

Any Violent Tendencies? Yes / No   Please describe the actions: __________________________

____

Personal Articles Normally Carried by the Client

Tobacco Products: Yes / No   Type: ____________   Brand: ___________________

Candy / Gum: Yes / No   Brand: ____

Matches: Yes / No   Lighter: Yes / No   Type: _______________________________________

Toys: Yes / No   Type: ____

Food Items: ____

Facial tissue or other pocket / purse items: Describe: ____________________________________

____

Approximate Cash on Hand: ___________   Where normally carried: _______________________

(Please circle one, if carried) Handbag / Purse / Wallet   Type: _________________________

Description: _________________________________   Color: _________________________

Jewelry (Please describe): ___

Watch: Wrist / Pocket / etc. (circle) Type: ___ Color: ___

Description: ___

What does the client value the most? ___

___

Which family member is the client closest to? ___

What is their relationship? ___

Where was the client born and raised? ___

Has the client received any letters recently? Yes / No (circle) From whom? ___

Is the client afraid of dogs? Yes / No (circle)

Is the client afraid of the dark? Yes / No (circle)

Is the client afraid of loud noises? Yes / No (circle)

Is the client afraid of horses? Yes / No (circle)

Is the client afraid of people? Yes / No (circle) Type: ___

Is the client afraid of anything else? ___

___

What does the client do when they are hurt? (Cry, shout, etc.) ___

___

Will the client talk to strangers? Yes / No (circle)

Is the client **DANGEROUS** to him/herself or others? Yes / No (circle)

Explain: ___

___

___

If Alzheimer's disease has been diagnosed, answer the following:

1. Does the client remain oriented to Time and Person? Yes / No Explain: __________
____

2. Does the client recognize familiar people and faces? Yes / No Explain: __________
____

3. Can the client travel to familiar locations? Yes / No Explain: __________
____

4. Does the client have decreased knowledge of current events or tend to re-live events in his / her life? Yes / No Explain: ____
____

5. Does the client sometimes clothe himself / herself improperly? Yes / No
Explain: (examples: shoes on the wrong feet, adding underwear over clothing, etc.) ____
____

6. Does the client remember his / her own name and the names of spouse(s) and/ or children? Yes / No Explain, if needed: ________________________________
____

7. Does the client have disrupted sleep patterns? Yes / No Explain: __________
____

8. Does the client suffer from frequent personality and emotional changes? Yes / No
Explain: ____

9. Does the client suffer from delusions (see Imaginary visitors, talk to his/ her own reflection in the mirror, imagine that their spouse is an imposter, etc.)? Yes / No
Explain: ____
____

10. How good is the client's communication ability? None / Poor / Fair / Good / Excellent (circle)

Caregiver / Billing Information

Name of Person filling out this form / Responsible Party and Relationship to client:

____

Facility / Organization (if any): ____

Address: ____

City / State: ______________________________ Zip: ________________________

Home / Cell Phone: ____________________________ Work Phone: ______________

Email: ____

Operator License Number & State: ____

Date of Birth: __________________ Social Security Number: ____________________

Billing Address: (If different from above):

Name: ____

Address: ____

City / State: ____________________________ Zip: __________________________

Home / Cell Phone: ________________________ Work Phone: ___________________

Email: ____

Family / Friend Contact Information

Other persons that the client may contact (friends, family, additional caretakers, etc.)

Name: ____________________________ Relationship: ________________________________

Address: ____

Phone: ___________________ Email: ____

Name: ____________________________ Relationship: ________________________________

Address: ____

Phone: ___________________ Email: ____

Name: ____________________________ Relationship: ________________________________

Address: ____

Phone: ___________________ Email: ____

Name: ____________________________ Relationship: ________________________________

Address: ____

Phone: ___________________ Email: ____

ADDITIONAL INFORMATION:

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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 THE YORK-POQUOSON PROJECT LIFESAVER. I UNDERSTAND THT THE DUTIES OF THE PROJECT LIFESAVER PERSONNEL IS TO INSPECT THE EQUIPMENT AND TO PROVIDE A MAINTENANCE / LOG SHEET ON A MONTHLY BASIS, TO REPLACE EQUPMENT IF NEEDED, AND TO SEARCH FOR THE CLIENT. I ALSO UNDERSTAND THAT THE EQUIPMENT BEING USED IS THE PROPERTY OF THE YORK-POQUOSON SHERIFF'S OFFICE PROJECT LIFESAVER PROGRAM AND UPON TEMINATION OF THE SERVICE, ALL EQUIPMENT IS TO BE RETURNED TO THE SHERIFF'S OFFICE AS SOON AS POSSIBLE.

THE COST PER MONTH TO PARTICIPATE IN THE YORK-POQUOSON PROJECT LIFESAVER PROGRAM IS DETERMINED AT THE BEGINNING OF THE CONTRACT AND REASSESSED AS NEEDED ON AN ANNUAL BASIS. THE COST COVERS THE MAINTENANCE AND REPLACEMENT OF EQUIPMENT AS NEEDED.

AT THIS TIME, THE COST IS $0.00.

____

Caregiver Signature

____

Date

____

Approving Deputy Signature

____

Date Transmitter Put in Operation

216.____

Frequency

Updated: 4/22/2021

INTERNATIONAL
PROJECT
LIFESAVER
"BRINGING LOVED ONES HOME"