Client Number: ______________________________ PLU Frequency: ____________________
Client Name: _________________________________ ID: ____________________

Project Lifesaver of Greater Victoria Client Profile

Date Transmitter Placed: ____
PLGV Servicer filling out this form: ____
PLGV Servicer that places transmitter on: ____
Responsible Party Paying for client: ____

Client's General Information

Client Name: ____
Client Address: ____
Client Phone #: ________________________________ How long at this address? _______________
Client DOB: __________________________________ Sex: Male: _________ Female: _________
Client's Height: ________________________________ Client's Weight: _______________________

Caregiver/Guardian Information/Authorization

Caregiver's Name: ____
Caregiver's Address: ____
Caregiver's Phone # - Home: _________________________ Mobile: _________________________
Caregiver's Email: ____
Caregiver's Relationship to Client: ____
Caregiver Authorization to Act for Client: ____

Client's Diagnosis & Wander History

Client's Clinical Diagnosis: ____
When was the Client Diagnosed? ____
Is there a history of wandering? Yes: _________________________ No: ______________________
If yes, how many times? _________When was last incident? ____________________________________
Details of wander incident:
____
____
____
Does the client have 24/7 supervision? ____
On a scale of 1-10 how concerned are you that wandering will occur again? ___________________

Client's Residence & Occupational Background

Previous address: ____
Most recent place of work: ____
Most recent occupation: ____
Familiar with local area? Yes/No How recently ____________________________ Days/Months/Years
If not local, what other areas are known to Resident? _____________________________________
____
Where was Resident born and raised? ____

Physical & On Person Description

Hair color __________________ Hair Style __________________ Eye Color __________________
Complexion ________________________ Build ____________________________ Beard Yes/No
Sideburns Yes/No Moustache Yes/No Balding Yes/No False Teeth Yes/No
Shape of facial features: Round/Square/Oval/Other ____
Distinguishing marks, scars, tattoos, etc. Describe ____
General Appearance ____
Does Resident wear glasses? Yes/No Contacts? Yes/No Sunglasses Yes/No.
Describe: ____
If resident wears glasses/contacts what degree of vision does he/she have without the eyewear?
None/Poor/Fair (Circle)
Does Resident wear a hearing aid? Yes/No
If yes, what type of hearing without Aid? None/Poor/Fair (Circle)

Personal Items Carried on Person

Facial tissue or other pocket/purse items: ____
Approximate Amount of Cash on Hand? $ ____
Where Normally Carried ____
Handbag, Purse or Wallet: Yes/No
Description ____
Do they wear: Jewellery or Watch
Describe: ____
Do they carry a: Cane or Walker
Other: ____

Personal Habits

Smoke? Yes/No Brand ____
Drink Alcohol? Yes/No What Type? ____
Is the Resident DANGEROUS to him/herself or others? Yes/No

Experience

Experience with: Military, Scouting, Outdoor, First Aid? Yes/No (Circle)
Describe: ____
Ever go out alone? Yes/No Describe: ____
Go for walks? Yes/No Stay on trails? Yes/No
General Athletic Interest/Abilities ____
Hobbies/Interests ____

Health/Psychological Condition

Any known physical handicaps? Yes/No
Describe: ____
Any known medical problems? Yes/No
Describe: ____
List any medication taken regularly using correct name of drug and dosage being taken:
____
____
____
____
____
____
Consequences of NOT taking medications? ____________________________________

____

Attending Physician ________________________________ Phone No. ________________
Any Psychological Problems? Yes/No
Describe: ____

Communication

If Resident does not understand English, what language is understood? ______________
Written Spoken or Both
Likes Groups or being alone? Yes/No (Circle)
Quiet, Outgoing, Approachable, Talk to Strangers? Yes/No (Circle)
Ever been in trouble with the law? Yes/No
Religious? Yes/No
Describe: ____
Has Resident received any communication recently? Yes/No
Describe: ____
Any fears: i.e. Dogs, Horses, People, Dark, Noises? Yes/No (Circle)
Other (explain) ____
What actions taken hurt? Cry, Swear, Shout, Call for Help - Yes/No (Circle)
Describe: ____

If Alzheimer's disease or dementia has been diagnosed, Answer the following:

1. Does the Resident remain oriented to Time and Person? Yes/No
   Explain ____
2. Does the Resident recognize familiar persons and faces? Yes/No
   Explain ____
3. Can the Resident travel to familiar locations? Yes/No
   Explain ____
4. Does the Resident have deceased knowledge of current events or tend to re-live events in his/her life? Yes/No
   Explain ____
5. Does the Resident sometimes clothe himself/herself improperly? Yes/No
   Example: Putting shoes on the wrong feet, adding underwear over clothing?
   Explain if necessary ____
6. Does the Resident remember his/her own name and the names of spouse and or children? Yes/No
   Explain ____
7. Are the Resident's sleep patterns frequently disturbed? Yes/No
   Explain ____
8. Does the Resident suffer from frequent personality and emotional changes? Yes/No
   Explain ____
9. 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?) Yes/No
   Explain ____
10. How good is the Resident's communication ability? None/Poor/Fair/Good/Excellent

Family/Friend Contact Information

Name of Spouse: ____ Living/deceased (circle)
Name: _______________________________________ Phone: _________________________
Address: ____
Relationship to client: ____
Name: ___________________________________ Phone: _____________________________
Address: ____
Relationship to client: ____

Places/Locations Client Frequents

____
____
____

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