

INSTRUCTIONS

Client Personal Data Questionnaire: pages 2,3,4,5

Please fill this portion as best and complete as you are able.

Lost Subject Profile: page 6

This form will be used when patient is reported missing. Keep this handy!

Program Contract: pages 7, 8

Please read and fill in the information on page 8.

Client Check Sheet: page 9

This form will be used by the caregiver to document the monitoring of the unit between visits of the Project Lifesaver staff.

Responder Sheet: page 10

This sheet will be used when the Project Lifesaver staff visits.

When this information is complete, contact Catawba County Sheriff's Office Project Lifesaver at 828-465-8336 to setup an appointment for us to come and complete the process of installing the device and provide instructions about the Program.

Payment options will be discussed and arranged.

Client Number: _____ Frequency: _____ ID Number or Code _____

Project Lifesaver: Catawba County Sheriff's Office
PO Box 385
Newton, NC 28658
Phone: 828-465-8336 or 828-464-5241 Fax: 828-465-8471

Client Personal Data Questionnaire

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.

Resident: _____
Address: _____
City/State: _____ Zip: _____
Phone: _____

Date Transmitter Placed: _____
Facility/Organization/Caregiver: _____ Phone: _____
Address: _____
Servicer filling out this form: _____
PL Servicer that places transmitter on: _____

Resident's Personal Data

Birthday: _____ Sex: Male/Female Race: _____
Nickname(s): _____
Most recent address: _____
Most recent place of work: _____
Most recent occupation: _____
Name of Spouse: _____ Living/deceased (circle)

Family/Friend Information

Other persons the resident might contact (family, friends, etc.)

Name: _____ Phone: _____
Address: _____
Relationship to client: _____

Name: _____ Phone: _____
Address: _____
Relationship to client: _____

Responsible Party Paying for client: _____

Diagnosis: _____

Physical Description

Height ____ft. ____in. Weight _____lbs. Build _____ Complexion _____

Hair color _____ Hair Style _____ Eye Color _____

Beard: Yes No Mustache: Yes No Balding: Yes No False Teeth: Yes No

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

Distinguishing marks, scars, tattoos, etc. _____

General Appearance _____

Languages other than English understood? _____

Speak? Yes No Read? Yes No Write? Yes No

Wear glasses? Yes No Contacts? Yes No Sunglasses Yes No

If yes to any of the above what style: _____

Degree of vision without eyewear? None Poor Fair (circle one)

Personal Data Questionnaire

Wear a hearing aid? Yes No What style? _____

If yes, what type of hearing without Aid? None/Poor/Fair (circle one)

Health/Psychological Condition

Any known physical handicaps? _____

Any known medical problems? _____

Medications taken regularly? _____

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

Consequences of NOT taking medications? _____

Attending Physician _____ Phone No. _____

Any Psychological Problems? Yes/No Nature _____

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

1. Remains oriented to Time and Person? Yes No
Explain _____
2. Recognizes familiar persons and faces? Yes No
Explain _____
3. Able to travel to familiar locations? Yes No
Explain _____
4. Has decreased knowledge of current events or tend to re-live events in his/her life? Yes No
Explain _____
5. Sometimes clothe himself/herself improperly? Yes No
Example: Putting shoes on the wrong feet, adding underwear over clothing?
Explain if necessary _____
6. Remembers his/her own name and the names of spouse and or children? Yes No
Explain _____
7. Sleep patterns frequent or Sporadic?
Explain _____
8. Suffer from frequent personality and emotional changes? Yes No
Explain _____
9. Suffers 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. Communication ability? None Poor Fair Good Excellent

Personal Articles Normally Carried by the Resident:

Tobacco Products: Yes No Type _____ Brand _____

Candy/Gum: Yes No Brand _____

Matches: Yes No Lighter: Yes No Type _____

Food Items: _____

Facial tissue or other pocket/purse items: _____

Approximate Cash on Hand? \$ _____

Where Normally Carried _____

Handbag, Purse or Wallet:

Description _____ Type _____ Color _____

Jewelry (Please describe) _____

Watch? _____ Type _____ Color _____ Description _____

Equipment

Cane or /Walker _____ Hunting/Fishing, Etc. _____ (circle one or describe)

Other: _____

Experience

Ever go out alone? Yes No Where _____
Familiar with area? Yes No How recently _____ Days/Months/Years
If not local, what other areas are known to Resident? _____

Taken outdoor classes? Yes No Where? _____ When? _____
Taken first-aid training? Yes No Where? _____ When? _____
Involved in Scouting? Yes No Explain _____
Military Experience? Yes No Where? _____ When? _____
Outdoor Experience? Yes No _____
Camping Experience? Yes No _____ Day or Night _____
Ever been lost before? Yes No Where? _____
When _____ Time of Day _____
Location found _____
Actions taken _____

General Athletic Interest/Abilities _____

Personality Habits

Smoke? Yes No How often _____ what _____ Brand _____
Drink Alcohol? Yes No What Type? _____ Brand _____
Use Illicit Drugs? Yes No How often _____ Type _____
Evidence of Leadership Yes No Explain _____
Any trouble with the law? Yes No Explain _____
Religious? Yes No What faith _____
Received mail recently? Yes No From Whom _____
Afraid of Dogs? Yes No The dark? Yes No Noises? Yes No
Horses? Yes No People? Yes No Other (explain) _____
Talks to strangers? Yes No
Dangerous to self/others Yes No

Outgoing or Quiet _____ Likes Groups or being alone? _____

What does Resident value most? _____

Which family member is resident closest to? _____ Relationship _____

Where was Resident born and raised? _____

Reactions to hurt or pain? (Cry, shout, etc.?) _____

**PROJECT LIFESAVER
LOST SUBJECT PROFILE**

INCD. NAME	DATE	TIME	INCD. CMDR.
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PERSONAL

NAME	NICKNAME	AGE	RACE	SEX
HOME ADDRESS	CITY	STATE		
NAMES OF FAMILY OR NEAREST RELATIVES				

PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	COMPLEXION	HAIR COLOR
HAIR STYLE	FACIAL HAIR	EYE COLOR	
DISTINGUISHING MARKS			

CLOTHING

<input type="checkbox"/> SHIRT	(description)		
<input type="checkbox"/> DRESS	(description)		
<input type="checkbox"/> SWEATER	(description)		
<input type="checkbox"/> PANTS	(description)		
<input type="checkbox"/> COAT	(description)		
<input type="checkbox"/> HAT	(description)		
<input type="checkbox"/> SHOES	SIZE	SOLE STYLE	TREAD PATTERN

PERSONAL ITEMS IN POSSESSION

<input type="checkbox"/> WALLET/PURSE
<input type="checkbox"/> JEWELRY
<input type="checkbox"/> TOBACCO
<input type="checkbox"/> CANDY/GUM
<input type="checkbox"/> EYE GLASSES
<input type="checkbox"/> KNIFE/TOOLS
<input type="checkbox"/> CANE STICK
<input type="checkbox"/> OTHER

ADDITIONAL NOTES OR PICTURE

PHYSICAL/MENTAL CONDITION

PHYSICAL	
MENTAL	
MEDICATION	
ALCOHOL	
ILLICIT DRUGS	
NOTES	

Additional Information:

Project Lifesaver

Program Contract

If applicant is accepted into the Project Lifesaver Program, the following terms shall apply as agreed to upon the signing of the Project Lifesaver contract:

I acknowledge that the information I have provided is true and accurate to the best of my knowledge. All information provided has been given voluntarily, and I consent to the collection, use and disclosure of such information for the purposes of Project Lifesaver. Furthermore, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the Applicant named below, to register and act on his/her behalf. My Power of Attorney and/or Power of Personal Care is attached, if needed.

THEREFORE, IN CONSIDERATION of the mutual promises and obligations contained herein, the sufficiency of which is acknowledged, the parties agree as follows, each to their respective obligations:

1. I understand that when I enroll an Applicant in Project Lifesaver, that it does not replace the need for constant supervised care of the person. I am, and remain, primarily responsible for supervised care and take fully responsibility of protecting this person from wandering. I also understand that I, or a family member, must be present in the home with the Applicant at all times.
2. I understand that Project Lifesaver equipment is designed to be an additional aid to help locate a missing person and that there is no warranty, representation or guarantee that a person will be found because they are wearing a Project Lifesaver bracelet. Project Lifesaver equipment is designed to provide law enforcement personnel with an additional technology in attempting to locate the Applicant. I also acknowledge that this is an experimental program for aiding in the search and rescue of persons suffering from diminished mental capacity or other disability.
3. In order for Project Lifesaver to work, I have a responsibility to obey the instructions of the Program, follow all training, and make sure that the person that I enroll is wearing the Project Lifesaver transmitter bracelet has been removed or is defective; I will call Project Lifesaver immediately.
4. When I notice that the Applicant enrolled has wandered off, I must immediately call the emergency number supplied by Project Lifesaver and report the Applicant as a missing person. Project Lifesaver teams will respond to search. I understand and acknowledge that the Project Lifesaver device cannot predict or report that the Applicant has wandered off. It is used solely as an aid for emergency personnel when notified the Applicant is missing.
5. A monthly maintenance fee of \$ 20.00 shall be payable at the 1st day of each month, by check or cash. Fees may be paid quarterly, semi-annual or yearly. An invoice will be mailed as required. If the device is lost or otherwise rendered unusable, the Responsible Party shall reimburse the Sheriff's Office the cost of said bracelet; cost is dependent on bracelet model: \$300.00 or \$350.00.
6. I understand that while Project Lifesaver is an electronic tracking device that assists in locating persons who wear the bracelet device, there may be unforeseen times or circumstances when individuals cannot be located even while wearing the transmitter bracelet. I will not hold Project Lifesaver or any of its employees or volunteers, Provincial or city Law Enforcement or Fire and Rescue Agencies (collectively the "Releases") involved liable for failure to locate the person using the system, and hereby release all such Releases from any claim, cause of action, loss or damages arising from any inability or delay in locating the Applicant.

7. I understand that all information I have provided in this application may be shared among Local Law Enforcement, Fire and Rescue, and other necessary agencies in the community where I reside. Therefore, I understand that none of the information I have provided or shall provide in the future can be considered confidential or protected or private when used for the purposes of the Project Lifesaver Program, [notwithstanding the provisions of the Personal Information Protection and Electronic Documents Act].

8. I specifically waive any rights to confidentiality to the Applicant's medical records by Project Lifesaver International or any of Project Lifesaver's member agencies which includes dissemination of such information. I confirm that I have the authority by which to waive such rights.

9. I understand that Project Lifesaver is a program administered by: Catawba County Sheriff's Office. I agree to release and hold each agency and all of their respective personnel, officers and volunteers harmless from any and all claims of liability and/or damage, and waive any and all rights to seek recourse for any losses or injury that may occur as a result of participation in the Project Lifesaver Program.

10. I understand that the transmitter and tester remain the property of Project Lifesaver and when no longer being used by the Applicant to whom it was assigned will be returned undamaged to Project Lifesaver to be assigned to another participant in the Program. I shall remain liable for any loss or damage to all such equipment and for the replacement cost of all such equipment until returned to Project Lifesaver.

11. I understand that if I fail to use the tester device at least once per day and record the results on the supplied test result monthly inspection sheet, or if I fail to notify Project Lifesaver immediately when I discover the Applicant missing, or if I fail to notify Project Lifesaver if I test the transmitter device and find no signal indication, or if the Applicant refuses to wear or removes the device 3 (three) times, then the Applicant may be involuntarily removed from the program. All property will then be returned to Project Lifesaver and I will return to the original security measures, which were in place prior to enrollment in Project Lifesaver, and without recourse to Project Lifesaver.

By signing below, I affirm that I have read and understand the contract including all waivers, releases, and liability limitations. It is my desire and intention to enter into this agreement and by affixing my signature below, I hereby agree to the terms and provisions of this contract.

CAREGIVERS SIGNATURE

CAREGIVERS NAME (PRINTED)

STREET ADDRESS/ PO BOX

CITY, STATE/ZIP

WITNESS (OR NOTARY) SIGNATURE

WITNESS (OR NOTARY) NAME PRINTED

STREET ADDRESS/PO BOX

CITY, STATE/ZIP

NOTARY COMMISSION EXPIRES

NOTARY IDENTIFICATION NUMBER

TELEPHONE NUMBER (CAREGIVER)

TELEPHONE NUMBER (NOTARY OR WITNESS)

PROJECT LIFESAVER REPRESENTATIVE

DATE

Project Lifesaver Client Check Sheet

Client Name	Client City/Zip	Client Location (Address)	Contact Phone
Caregiver Contact	Caregiver Phone	Caregiver Relationship	

Client Facility
 House
 Apt.
 Duplex
 Trailer
 Hospital
 Nursing Home
 Asst. Living
 Secured
 Fenced

Day	Month	Time	Person Inspecting Equipment	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

	Transmitter	Battery	Case	"O" Ring	Band	Tester	Sheet
Install/New	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replace/Modify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Visit1) _____	Caregiver Signature	Date	Responder Signature	Date
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Visit2) _____	Caregiver Signature	Date	Responder Signature	Date
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Responder Information:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Battery Working When Inspected/Changed | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Transmitter Working When Inspected/Changed | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Case Damaged Prior to Inspection/Change | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Band Damaged Prior to Inspection/Change | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Unauthorized Removal of Transmitter/Band | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) "O" Ring replaced | <input type="checkbox"/> | <input type="checkbox"/> |

Client Condition since Last Visit:

1) Personality or Behavior

- | | | | | | |
|------------------------------------|---|---|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Change | <input type="checkbox"/> Violent | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Agitated | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Passive |
| <input type="checkbox"/> No Change | <input type="checkbox"/> Paranoid | <input type="checkbox"/> Depressed | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Pleasant | <input type="checkbox"/> Accusatory |
| | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Hides Things | <input type="checkbox"/> Disrobes in Public | <input type="checkbox"/> Assault |
| | <input type="checkbox"/> Theft | <input type="checkbox"/> Other Criminal Conduct | | <input type="checkbox"/> Traffic Violation | |
| | <input type="checkbox"/> Other Inappropriate Behavior _____ | | | | |

2) State of Mind

- | | | | |
|------------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Change | <input type="checkbox"/> Memory Loss Short Term | <input type="checkbox"/> Memory Loss Long Term | <input type="checkbox"/> Confused |
| <input type="checkbox"/> No Change | <input type="checkbox"/> Cannot recognize friends | <input type="checkbox"/> Cannot recognize family members | |
| | <input type="checkbox"/> Trouble Thinking | <input type="checkbox"/> Cannot recognize familiar places | |
| | <input type="checkbox"/> Other _____ | | |

3) Life State

- | | | | |
|------------------------------------|--|---|---|
| <input type="checkbox"/> Change | <input type="checkbox"/> Needs help dressing | <input type="checkbox"/> Personal Hygiene Deteriorating | <input type="checkbox"/> Appetite declining |
| <input type="checkbox"/> No Change | <input type="checkbox"/> writing deteriorating | <input type="checkbox"/> Speech deteriorating | <input type="checkbox"/> Stopped Eating |
| | <input type="checkbox"/> Not taking medicine | <input type="checkbox"/> Declining potty habits | |
| | <input type="checkbox"/> Cannot Travel alone | <input type="checkbox"/> Cannot be left alone | <input type="checkbox"/> Cannot navigate |
| | <input type="checkbox"/> Confused | <input type="checkbox"/> Wanders | <input type="checkbox"/> Trouble Thinking |
| | | | <input type="checkbox"/> Cannot drive |
| | | | <input type="checkbox"/> Other _____ |

4) Sleep

- | | Morning (0600-1159) | Afternoon(1200-1800) | Evening (1800-2359) | Night (2400-0559) |
|------------------------------------|---|---|---|-------------------|
| <input type="checkbox"/> Change | <input type="checkbox"/> Morning to Afternoon | <input type="checkbox"/> Morning to Evening | <input type="checkbox"/> Morning to night | |
| | <input type="checkbox"/> Afternoon to Evening | <input type="checkbox"/> Afternoon to Night | <input type="checkbox"/> Afternoon to Morning | |
| | <input type="checkbox"/> Evening to night | <input type="checkbox"/> evening to morning | <input type="checkbox"/> Evening to afternoon | |
| <input type="checkbox"/> No Change | <input type="checkbox"/> Night to morning | <input type="checkbox"/> night to afternoon | <input type="checkbox"/> night to evening | |
| | <input type="checkbox"/> Sleeps 2 hours | <input type="checkbox"/> sleeps 4 hours | <input type="checkbox"/> sleeps 6 hours | |

5) Equipment

- Client does not like to wear transmitter
- transmitter uncomfortable
- band/case chafing skin
- band/case irritating skin
- client removed band/transmitter
- client removed band/transmitter (hid/threw away transmitter)

Other Comments of Information:
