

**EXETER 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 _____ # _____

Vehicle(s): State: _____ Plate #: _____ State: _____ Plate # _____

Narrative: _____

Persons to Contact in Case of an Emergency:

Name: _____ Telephone #: _____

Relationship _____

Name: _____ Telephone #: _____

Relationship _____

Name: _____ Telephone #: _____

Relationship _____

Medical Information:

Preferred Hospital: _____ Telephone #: _____

Primary Care Physician: _____ Telephone #: _____

Allergies: _____

Medications: _____

Physical Limitations: _____

_____ **CHECK IF A PHOTOGRAPH IS ATTACHED**

_____ **SAFETY ID REQUESTED**