



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

[Type text]

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: _____

[Type text]

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 decreased 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

[Type text]

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

Support Project Lifesaver of Greater Victoria

All programs/services offered through We Rage We Weep Alzheimer Foundation operate on a donation basis. The suggested donation to participate in the Project Lifesaver program is \$300.00. Funds go to equipment, training and ongoing support. As we are a registered charity you will receive a tax receipt for your contribution. Thank you so much for making a difference in the day to day lives of caregivers and for helping bring loved ones home!

To make your contribution

Please go to www.werageweweeep.com & click on



or

Make your cheque or money order payable to
We Rage We Weep Alzheimer Foundation and mail to:
707-828 Rupert Terrace
Victoria, BC V8W 0A7

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