



**SEABROOK POLICE DEPARTMENT  
ALZHEIMER'S and INDIVIDUALS WITH SPECIAL NEEDS  
ASSISTANCE PROGRAM**

**PATIENT INFORMATION:**

SSN: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

DOB: \_\_\_\_\_ Driver's License (State): \_\_\_\_\_ # \_\_\_\_\_

Address: # \_\_\_\_\_ Street: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Glasses: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hair: \_\_\_\_\_

Speech: \_\_\_\_\_ Facial Hair: \_\_\_\_\_ Complexion: \_\_\_\_\_ Handed: \_\_\_\_\_

Vehicle(s): State: \_\_\_\_\_ Plate #: \_\_\_\_\_ State: \_\_\_\_\_ Plate #: \_\_\_\_\_

Narrative: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Photo Included: \_\_\_\_\_ Date of Photo: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Relationship): \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Relationship): \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Relationship): \_\_\_\_\_ Address: \_\_\_\_\_

**MEDICAL INFORMATION:**

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_