

**WOLFEBORO POLICE DEPARTMENT
ALZHEIMER PATIENT INFORMATION SHEET**

Patient Information: _____ SSN: _____

Last Name: _____ First: _____ MI: _____

Address: # _____ Street: _____ Apt# _____

City _____ State: _____ Zip: _____ Phone#: _____

DOB: _____ Race: _____ Sex: _____ Ethnicity: _____ Glasses: _____

Height: _____ Weight: _____ Hair: _____ Eyes: _____ Body: _____

Speech: _____ Facial Hair: _____ Complexion: _____ Handed: _____

Photo taken: _____ Date: _____ Driver's License State: _____ Number: _____

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

NARRATIVE: _____

Person to contact in case of an Emergency:

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Medical Information:

Preferred Hospital: _____ Telephone# _____

Primary Care Physician: _____ Telephone# _____

Allergies: _____

Medication: _____

Physical Limitations: _____