LEBANON 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:_____ Ears:_____ Body:_____ Face:_____

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

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

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

NARRATIVE: _____
_____
_____
_____
_____
_____

Persons to Contact in case of an Emergency:
Name: _____ Telephone #:_____
Relationship: _____
Name: _____ Telephone #:_____
Relationship: _____
Name: _____ Telephone #:_____
Relationship: _____
Name: _____ Telephone #:_____
Relationship: _____
Name: _____ Telephone #:_____
Relationship: _____

Medical Information:
Preferred Hospital: _____ Telephone #:_____
Primary Care Physician: _____ Telephone#:_____
Allergies: _____
Medications: _____
Physical Limitations: _____
_____