|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | | | | | | | | | | | **Nickname** | | | |  | | | | |
| Juanita Gomez | | | | | | | | | | |  | | | | Image of sample client, Juanita Gomez | | | | |
| **Current Address** | | | | | | | | | | | | | | |
| 45 Shade Street, Treetop MA 00000 | | | | | | | | | | | | | | |
| **Former Address** | | | | | | | | | | | | | | |
| 43 Main St., Oldtown MA 00000 | | | | | | | | | | | | | | |
| **Sex** | **Race** | **D.O.B.** | | **Age\*** | **Height\*** | | **Weight\*** | | **Build** | | | **Hair** | | **Eyes** |
| F | Latino | 5-16-81 | | 36 | 5”8” | | 188 | |  | | | BL | | BR |
| **Distinguishing Marks** | | | | | | | | | | | | | | |
| Scar on right hand | | | | | | | | | | | | | | |
| **Legal Competency Status** | | | | | | | | | | | | | | |
| Incompetent | | | | | | | | | | | | | | |
| **If Legal Guardian, Name** | | | | | | | | | | **Phone** | | | | |
| NA | | | | | | | | | |  | | | | |
| **Address** | | | | | | | | | | **Work** | | | | |
|  | | | | | | | | | |  | | | | |
| **Family Address (if different)** | | | | | | | | | | **Phone** | | | | |
| 43 Main St. | | | | | | | | | | 617-000-0000 | | | | |
| Oldtown MA 00000 | | | | | | | | | |  | | | | |  | | | | |
| **Training / Work Program** | | | | | | | | **Address** | | | | | | | | | | **Phone** | |
| Amercare Services | | | | | | | | 13 Main Street Treetop MA 00000 | | | | | | | | | | 617-000-0000 | |
| **Relevant Emergency Medical Information: (Allergies, Medications, etc.)** | | | | | | | | | | | | | | | | | | | |
| Allergies-Bactrim | | | | | | | | | | | | | | | | | | | |
| Diagnoses-Seizure disorder, chronic muscle pain, chronic constipation, dysphagia | | | | | | | | | | | | | | | | | | | |
| **Physician’s Name** | | | | | | | | **Address** | | | | | | | | | | **Phone** | |
| Dr. David Jones | | | | | | | | 523 Washington Street, Treetop MA 00000 | | | | | | | | | | 617-000-0000 | |
| **Language / Communication** | | | | | | | | | | | | | | | **Ability to protect self w/o assistance** | | | | |
| Uses facial expressions and nods her head yes or no when communicating likes and dislikes | | | | | | | | | | | | | | | No | | | | |
|  | | | | | | | | | | | | | | |  | | | | |
| **Significant Behavior Characteristics** | | | | | | | | | | | | | | | **Likely Response To Search Efforts** | | | | |
| None | | | | | | | | | | | | | | | Poor | | | | |
|  | | | | | | | | | | | | | | |  | | | | |
| **Pattern of Movement (if lost previously)** | | | | | | **Places Frequented** | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | | | | | | |
| **Relevant Capabilities:** | | | | | | | **Limitations:** | | | | | | | | **Preferences:** | | | | |
| Dependent with ADLs | | | | | | |  | | | | | | | | Enjoys being outdoors | | | | |
| **Probable Dress\*** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Where and When the person was last seen** | | | | | | | | | | | | | | | **Date\*** | | | | **Time\*** |
|  | | | | | | | | | | | | | | | | | | | |
| **Emergency Contacts** | | |  | | | | | | | | | |  | | | |  | | |
| **F****AMILY / GUARDIAN** | | | Marguerite Gomez (mother) | | | | | | | | | | **DDS** | | | | Sky Johnson, Service Coordinator | | |
| **RESIDENCE** | | | Linda White, Program Manager | | | | | | | | | |  | | | |  | | |
| Note: Asterisked (\*) items are left blank on the original and filled in on copy if and when the individual is lost. Except age, height, and weight which must be recorded at all times on the form. | | | | | | | | | | | | | | | | | | | |
| **NAME** | | | | | | | COMMONWEALTH OF MASSACHUSETTS | | | | | | | | | **AREA** | | | |
| Juanita Gomez | | | | | | |  | | | | | | | | | Anywhere Area Office | | | |
| **RECORD LOCATION** | | | | | | |  | | | | | | | | |  | | | |
| 45 Shade Street | | | | | | | **EMERGENCY** | | | | | | | | |  | | | |
| Treetop MA 00000 | | | | | | | **FACT SHEET** | | | | | | | | |  | | | |