

TOWN OF DEDHAM

COMMONWEALTH OF MASSACHUSETTS



DEPARTMENT OF POLICE

PRENOTIFICATION FOR POTENTIAL WANDERING

Instructions: Complete form, return to the Police Department.			
Name of potential wanderer:			
Lives With:			
Relationship to Patient:			
Address:			
Telephone E-Mail			
Neighbor or Other Local Contact:			
Relationship:			
Address:			
Telephone:E-Mail			
Other Family Contact:			
Relationship:			
Address:			
Telephone:E-Mail			
POTENTIAL WANDERER INFORMATION			
Date of Birth: SS# (optional) Height'" Weight			
Eye Color Hair Color Glasses? Yes / No / Contacts			
Identifying Scars / Deformities			
Does Patient Attend Day Care? Yes / No Where?			

The mission of the Dedham Police Department is to protect and serve the citizens of Dedham through collaboration, preventative programs and the judicious enforcement of the laws of the Commonwealth of Massachusetts and the by-laws of the Town of Dedham.



TOWN OF DEDHAM

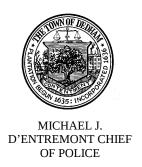
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www.dedhampolice.org

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Patient's Doctor:		
Insurance Company:	Number:	_
Any Medication?		
Diagnosis		
	HABITS	
Does Patient Wander? Yes	/ No If So, In Any Particular Direction Or Place?	
What Language Does The I	Patient Speak?	
Any Speech or Hearing Pro	blems?	
Habits or Patterns of Behav	ior?	
Is Patient Physically or Ver	bally Abusive?	
	nts?	



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600 High Street Dedham, MA 02026 Phone 781-751-9300 Fax 781-751-9330 www.dedhampolice.org

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RELEASE FORM

confidentially on file for the purposes of i	, give my permission to the Dedham Police Aging to retain the information, to be kept dentification and assistance relative to response ports involving cognitive impairment and related
	Signature:
	Date: