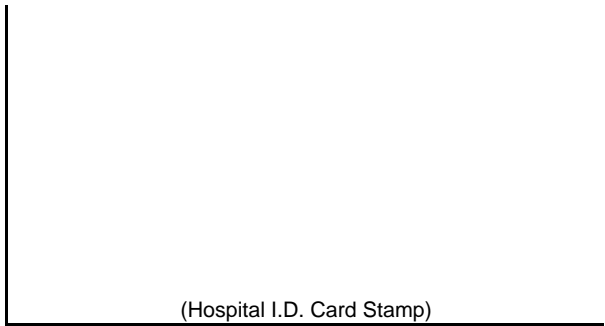


# ARHA IDENTIFICATION FORM

COMPLETE IMMEDIATELY for Disaster Codes:  
Pink, Yellow, Purple, White or Black



(Hospital I.D. Card Stamp)

CLIENT NAME: \_\_\_\_\_

CLIENT UNIT: \_\_\_\_\_

PREFERRED/NICK NAME: \_\_\_\_\_

MISSING FROM: Location \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

LAST SEEN: Location \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

BY WHOM: \_\_\_\_\_ Is this Client Certified under the Mental Health Act?  No  Yes

<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Skin Color</b> <input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> First Nation <input type="checkbox"/> White <input type="checkbox"/> Yellow		<b>Build</b> <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light <input type="checkbox"/> Muscular		<b>Language(s)</b> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Ukranian <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> Chinese <input type="checkbox"/> Janenese <input type="checkbox"/> Other:									
<b>Weight</b> Approx. if unknown		<b>Height</b> Approx. if unknown		<b>Age</b> Approx. if unknown		<b>Hair Color</b> <input type="checkbox"/> Blond <input type="checkbox"/> Red <input type="checkbox"/> Brown <input type="checkbox"/> Black <input type="checkbox"/> Grey <input type="checkbox"/> Part Grey <input type="checkbox"/> White <input type="checkbox"/> Other:		<b>Hair Style</b> <input type="checkbox"/> Bald <input type="checkbox"/> Short <input type="checkbox"/> Shoulder Lgth <input type="checkbox"/> Long <input type="checkbox"/> Curly <input type="checkbox"/> Straight <input type="checkbox"/> Wavy <input type="checkbox"/> Other:							
<b>Distinguishable Features</b> Please check appropriate features. <input type="checkbox"/> Eye Glasses/Contacts <input type="checkbox"/> Mustache/Beard <input type="checkbox"/> Hearing/Speech Impaired <input type="checkbox"/> Other: _____ Indicate location on diagram using the corresponding letter. <input type="checkbox"/> A - Moles <input type="checkbox"/> B - Birthmarks <input type="checkbox"/> C - Scars <input type="checkbox"/> D - Pierced Ears/Other <input type="checkbox"/> E - Tattoos <input type="checkbox"/> F - Cast <input type="checkbox"/> G - Bandages <input type="checkbox"/> H - I.V. Site <input type="checkbox"/> I - Catheter & Bag <input type="checkbox"/> J - Amputated Body Part <input type="checkbox"/> K - Other:								<b>Clothing</b> <input type="checkbox"/> Shirt/Blouse <input type="checkbox"/> Shoes/Boots <input type="checkbox"/> Dress/Skirt <input type="checkbox"/> Trousers <input type="checkbox"/> Sweater <input type="checkbox"/> Coat/Jacket <input type="checkbox"/> Pyjamas <input type="checkbox"/> Robe <input type="checkbox"/> Hospital Gown <input type="checkbox"/> Hat Other:				<b>Color &amp; Description</b> _____ _____ _____ _____ _____ _____ _____ _____ _____			
<b>Patient Condition</b> <input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Depressed				<input type="checkbox"/> Homicidal <input type="checkbox"/> Intoxicated <input type="checkbox"/> Suicidal <input type="checkbox"/> Uncooperative				<input type="checkbox"/> Potentially Violent <input type="checkbox"/> Verbally/Physically Aggressive <input type="checkbox"/> Needs Medical Attention <input type="checkbox"/> Needs Medication				<b>Form Completed by:</b> (Please Print)			