



**WESTFIELD POLICE DEPARTMENT**  
15 WASHINGTON STREET  
WESTFIELD, MA 01085  
TEL: 562-5411 FAX - 413-572-6551

**AUTISM ALERT**

**Instructions: Complete this form, attach a photograph of the Patient and return to The Westfield Police Department.**

Individual's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Individual's Nickname \_\_\_\_\_

Address \_\_\_\_\_, Westfield, MA  
Street and Number

Height \_\_\_\_\_ Weight \_\_\_\_\_ Color of Eyes \_\_\_\_\_ Color of Hair \_\_\_\_\_ Identifying scars, marks or tattoos \_\_\_\_\_

School Attending \_\_\_\_\_

Behavioral Pattern \_\_\_\_\_

Best Communication Method \_\_\_\_\_

Does the Individual live with anyone? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, list with whom, \_\_\_\_\_

Relationship to the Individual, \_\_\_\_\_ Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell Phone \_\_\_\_\_

List closest contact not living with the Individual \_\_\_\_\_ Relationship to Individual \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_  
Street, City, State

Neighbor or Other local contact \_\_\_\_\_ Relationship to Individual \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_  
Street, City, State

Other family member contact \_\_\_\_\_ Relationship to Individual \_\_\_\_\_

Address \_\_\_\_\_ Phone Number (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_  
Street, City, State

Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Additional Information \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ATTACH A RECENT PHOTOGRAPH  
HEAD AND SHOULDERS PREFERRED