Night Owl Support Systems

Referral Form

Please Print and fill out completely if possible.

REQUESTED SERVICES FOR:

Name: _____ Date of Referral:_____

Address: _____ Landline Phone:_____

City/State/Zip _____ Cell Phone: _____

DOB:_____

Member ID #/Medicaid#/Billing #_____

Preferred time of Night Owl services? Now☐ 3-6 months☐ 1 year☐ Other_____

Guardian(s):_____Phone:_____

Residential Provider: _____ Phone:_____

Email: _____

CMO/Case Manager:_____ Phone:_____

Email: _____

Insurance Provide/Billing Provider: :_____

Phone:_____

Email: _____

Housemate(s):_____

Medical/Health:

Diagnosis:_____

Primary Doctor:_____Clinic:_____Phone:_____

Hospital Preference_____ Phone:_____

Medications: (please list time and dose as well)

_____

_____

_____

Hearing: _____

Communication:_____

Can the individual use a phone independently? Yes☐ No☐ A pager? Yes☐ No☐

Vision:_____

Mobility:_____

Can this individual exit his/her house in an emergency independently? Yes ☐ No ☐

Can this individual exit his/her house in an emergency if told so via phone? Yes ☐ No ☐

Other Concerns (Seizures etc.):_____

_____

Sleeping Patterns:

Describe individuals typical sleeping pattern (time in bed, awake, how many hours, heavy sleeper, if they get up during the night etc.)

_____

_____

_____

_____

What is the current support system during night time hours? (live-in, shift staff, etc.).

_____

Behavioral Information:

Behavioral "issues"/challenges:_____

_____

_____

_____

Can both males and females work with this individual in all situations? Yes ☐ No ☐

If no please explain_____

_____

Please explain any other important information someone would need to know when supporting this individual during night time hours._____

_____

_____

_____

Person Completing Form_____

Relationship to the individual:_____

Signature:_____Date_____