NIGHT OWL SUPPORT SYSTEMS, LLC

REQUESTED SERVICES FOR:

Name: _____ Date of Referral: _____

Address: _____ Phone: _____

_____ DOB: _____

Social Sec. # _____

DX/CC

Codes: _____ Dane County ACS # _____

Preferred Time of Night Owl? Now ☐ 3-6 months ☐ 1 year ☑ Other:

Guardian(s): _____ Phone: _____

Residential Provider: _____ Phone: _____

Residential CM: _____ Phone: _____

Broker: _____ Contact: _____ Phone: _____

Housemates: _____

Voc Provider: _____ Contact: _____ Phone: _____

Type of Work the Individual Does:

Medical/Health:

Diagnosis: _____

Primary Doctor: _____ Clinic: _____ Phone: _____

Psychiatrist: _____ Clinic: _____ Phone: _____

Pharmacy: _____ Phone: _____ On-call #: _____

Medications: (Please list time and dose as well)

Can the individual administer his or her own medication? Yes ☐ No ☐

Seizures? Yes ☐ No ☐ If yes, describe in detail:

Allergies:

Communication:

Can the individual use a phone independently? Yes ❒ No ❒
Can the individual push a button for help? Yes ❒ No ❒
Vision:

Mobility: Does this individual use a walker, crutches, wheelchair, or other devices to mobilize?
Yes ❒ No ❒ If yes, please explain:

Other assistive devices (contacts, glasses, hearing aides, etc.):

Can the 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 medical/health concerns:

Sleeping Patters:
How many hours does the individual sleep during a night:

Typical time asleep (weekend/weekday):

Weekend:

Weekday:

Typical time awake (weekend/weekday):

Weekend:

Weekday:

What type of night support is this individual contracted to receive? (live-in, shift staff, etc. please include weekends)

What type of night time support is this individual currently receiving?

How many times does this individual get out of bed?

a night:		a week:		a month:		a year:	

Typical reasons:

If this individual awakes, what are the best way(s) to intervene?

Does this individual get scared or frightened during….

Rain ❒ Snow ❒ Thunderstorms ❒ Lightening ❒ Power Outage ❒ Other ❒

If yes, please explain reactions:

Does the individual generally sleep the same hours during all seasons? Yes ❒ No ❒

If no, please explain:

Approximately how many times does this client need assistance from a staff during sleep hours each..

a night:		a week:		a month:		a year:	

Approximately how many times has an "on-call" service been used in regards to this individual between

a night:		a week:		a month:		a year:	

Routines:

Amount of staff hours "required" and/or "needed during the A.M. hours:

Amount of staff hours "required" and/or "needed during the P.M. hours:

Typical weekly schedule/routine:

Time:	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

(Also used for responders to set up visits)

Behavioral Information:

Behavioral "issues"/challenges:

Stressors:

Best way to intervene:

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

If no, please explain:

individual during night time hours:

Activities/Interests:

Person Completing Form:
Relationship to the individual:
Date:

Signature Page:

Residential Agency

Signature _____

Print: _____

County Case Manager

Signature _____

Print: _____

Broker

Signature _____

Print: _____

Guardian

Signature _____

Print: _____

Other

Signature _____

Print: _____

County Supervisor approval (Monica Bear): Yes ❒ No ❒ Date: _____

SR Authorized Signature: _____

Please print out last page for signatures and send in to:
Sound Response Fax: 263-4681
122 E. Olin Ave.
Madison, WI 53713