NIGHT OWL SUPPORT SYSTEMS, LLC

## REQUESTED SERVICES FOR:

Name: _____ Date of Referral: _____

Address: _____ Phone: _____

DOB: _____

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

Guardian(s): _____ Phone: _____

Residential Provider: _____ Phone: _____

Residential CM: _____ Phone: _____

CMO/ICA _____ Contact: _____ Phone: _____

FEA (if applicable) _____

Housemates: _____

**Medical/Health:**

Diagnosis: _____

Primary Doctor: _____ Clinic: _____ Phone: _____

Psychiatrist: _____ Clinic: _____ Phone: _____

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

Medications: (Please indicate where the list can be located in the home)

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:

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

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: | |
|---|---|---|---|---|---|---|---|

**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:

**How did you hear about NOSS Services:**

**Person Completing Form:**

**Relationship to the individual:**

**Date:**