



NIGHT OWL SUPPORT SYSTEMS, LLC

**REQUESTED SERVICES FOR:**

Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
Address: \_\_\_\_\_ Landline: \_\_\_\_\_  
\_\_\_\_\_ Cellular: \_\_\_\_\_  
\_\_\_\_\_ DOB: \_\_\_\_\_

Anticipated Start Date? \_\_\_\_\_  
Guardian(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Residential Provider: \_\_\_\_\_

Residential CM: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

CMO/ICA/Case Manager: \_\_\_\_\_ Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

FEA (if applicable): \_\_\_\_\_

Housemates (include names): \_\_\_\_\_

Pets? Yes  No  If yes, what kind? \_\_\_\_\_

Are you a smoker? Yes  No

**Medical/Health:**

Diagnosis: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

Medications: (Please indicate where the list can be located in the home, no need to list)

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

Other Concerns? (Seizures, elopement, fall risk, food seeking, allergies, etc?) Please describe in detail.

**Communication Concerns:**

Can the individual use a phone independently? Yes  No

Can the individual push a button for help? Yes  No

**Vision/Hearing Concerns:**

Mobility Concerns: If yes, Please explain:

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 Patterns:**

Please describe overnight activity:

Does this individual get scared or frightened during....

Rain  Snow  Thunderstorms  Lightening  Power Outage  Other

If yes, please explain reactions and support strategies:

**Behavioral Information:**

Behavioral "issues"/challenges, if any:

Best way to intervene:

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

Person Completing Form: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Relationship to the individual: \_\_\_\_\_

Date: \_\_\_\_\_