NIGHT OWL SUPPORT SYSTEMS, LLC

REQUESTED SERVICES FOR:

Name: ______________________ Date of Referral: ______________
Address: ______________________ Phone: ______________
DOB: ______________________ Cell Phone: ______________
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 incate 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, elopment, 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 Patters:

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: ____________________________________