NIGHT OWL SUPPORT SYSTEMS, LLC

REQUESTED SERVICES FOR:

Name: _____ Date of Referral: _____

Address: _____ Landline: _____

_____ Cellular: _____

_____ DOB: _____

Anticipated Start Date? _____

Guardian(s): _____ Phone: _____

CLC Contact Person: _____ Phone: _____

Email: _____

MCO/IC

Provider: _____ Contact: _____ Phone: _____

Email: _____

FEA (if any):

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.

Vision/Hearing Concerns:

Communication Concerns:

Mobility Concerns: If yes, Please explain:

Can the individual use a phone independently? Yes ❒ No ❒

Can the individual push a button for help? Yes ❒ No ❒

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: (if known)

Please Descripe Sleeping Pattern:

Behavioral Information: "Issues"/Challenges

What level of service: (Level 1-4)

Equipment Neets/Responder Contact and Texting Info:
(be specific with sensor type and name - Front door, fridge sensor, hallway motion, etc)

Person Completing Form: _____ Date: _____