



ADULT PROTECTIVE SERVICES UNIT REFERRAL

DIVISION OF SENIOR CITIZENS ♦ DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
 P.O. BOX 2816, HAGÁTÑA, GUAM 96932 Ph: 735-7382 or 7384



Transmittal of this referral form via facsimile is strictly prohibited. Please print clearly using black or blue ink.

REFERRAL INFORMATION	
Referral taken by:	
Date:	
Time:	
Referring Person:	<input type="checkbox"/> Anonymous (Enter check {√} if appropriate)
Agency:	
Phone No.:	
Contact Person:	
Phone No.:	

TYPES OF ABUSE (Enter check {√} in appropriate box)			
<input type="checkbox"/>	Abandonment	<input type="checkbox"/>	Mental/Emotional
<input type="checkbox"/>	Material/Financial	<input type="checkbox"/>	Neglect
<input type="checkbox"/>	Physical	<input type="checkbox"/>	Sexual
<input type="checkbox"/>	Self Neglect	<input type="checkbox"/>	Other: _____

CLIENT INFORMATION				
Client Status: (Enter check {√} in appropriate box)	<input type="checkbox"/>	New	<input type="checkbox"/>	Active
	<input type="checkbox"/>	Former	<input type="checkbox"/>	Deceased; D.O.D.: _____
	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
	<input type="checkbox"/>	Elderly	<input type="checkbox"/>	Disabled
	<input type="checkbox"/>	Dual	<input type="checkbox"/>	
Last Name:				
First Name:				
Middle Name:				
Home Address: (Please include directions, description, landmarks, etc.) <input type="checkbox"/> Map on back				
Village:				
Current Physical Location:				
Phone No.:	(H)		(W)	
Ethnicity:				
Citizenship:				
Birth Date:				
Age:				
Marital Status: (Enter check {√} in appropriate box)	<input type="checkbox"/>	Single	<input type="checkbox"/>	Married
	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Divorced
	<input type="checkbox"/>	Other: _____		
Disability:				

ALLEGED ABUSER INFORMATION				
Last Name:				
First Name:				
Middle Name:				
Relationship:				
Address: (Please include directions, description, landmarks, etc.)				
Village:				
Phone No.:	(H)		(W)	
Ethnicity:				
Gender:	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
Birth Date:				
Age:				
Marital Status: (Enter check {√} in appropriate box)	<input type="checkbox"/>	Single	<input type="checkbox"/>	Married
	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Divorced
	<input type="checkbox"/>	Other: _____		

FOR USE BY APS STAFF ONLY				
Case No.:				
Referral No.:				
Database Entered by:				
Assigned Worker:				
Date Assigned:				
Reports:	24 Hour / 7 Day:	14 Day:		
	30 Day:	60 Day:		
Continued on back?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

