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Clear Form

ADULT PROTECTIVE SERVICES UNIT REFERRAL

DIVISION OF SENIOR CITIZENS ♦ DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
P.O. BOX 2816, HAGÅTÑA, 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:	☐ Anonymous *(Enter check { √ } if appropriate)*
Agency:	
Phone No.:	
Contact Person:	
Phone No.:	

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

TYPES OF ABUSE *(Enter check { √ } in appropriate box)*			
☐	Abandonment	☐	Mental/Emotional
☐	Material/Financial	☐	Neglect
☐	Physical	☐	Sexual
☐	Self Neglect	☐	Other: _____

ALLEGED ABUSER INFORMATION				
Last Name:				
First Name:				
Middle Name:				
Relationship:				
Address: *(Please include directions, description, landmarks, etc.)*				
Village:				
Phone No.:	(H)		(W)	
Ethnicity:				
Gender:	☐	Male	☐	Female
Birth Date:				
Age:				
Marital Status: *(Enter check {√} in appropriate box)*	☐	Single	☐	Married
	☐	Widowed	☐	Divorced
	☐	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?	☐	Yes	☐	No

(Continued from page 1)

Nature and extent of abuse:

Emergency action taken:	☐ **Referred to APS Social Worker on** *(Enter date & time)*: