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ADULT PROTECTIVE SERVICES REFERRAL

DIVISION OF SENIOR CITIZENS ♦ DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
123 Chalan Kareta, Mangilao, Guam 96913-6304 Ph: 735-7415 or 7421

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	☐	Adult with a Disability
	☐	Elderly with a Disability (Dual)		
Last Name:				
First Name:				
Middle Name:				
Home Address: *(Please include directions, description, landmarks, etc.)* ☐ **Map on back**				
Village:				
Current Physical Location:				
Phone No.:				
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	☐	Emotional or Psychological
☐	Financial or Property Exploitation	☐	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.:				
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)*:**

MAP: