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: