



**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 <input type="checkbox"/> if appropriate)
Agency:	
Phone No.:	
Contact Person:	
Phone No.:	

CLIENT INFORMATION				
Client Status: (Enter check <input type="checkbox"/> 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"/>	Adult with a Disability
	<input type="checkbox"/>	Elderly with a Disability (Dual)		
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.:				
Ethnicity:				
Citizenship:				
Birth Date:				
Age:				
Marital Status: (Enter check <input type="checkbox"/> in appropriate box)	<input type="checkbox"/>	Single	<input type="checkbox"/>	Married
	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Divorced
	<input type="checkbox"/>	Other:		
Disability:				

TYPES OF ABUSE (Enter check <input type="checkbox"/> in appropriate box)			
<input type="checkbox"/>	Abandonment	<input type="checkbox"/>	Emotional or Psychological
<input type="checkbox"/>	Financial or Property Exploitation	<input type="checkbox"/>	Neglect
<input type="checkbox"/>	Physical	<input type="checkbox"/>	Sexual
<input type="checkbox"/>	Self-Neglect	<input type="checkbox"/>	Other:

ALLEGED ABUSER INFORMATION				
Last Name:				
First Name:				
Middle Name:				
Relationship:				
Address: (Please include directions, description, landmarks, etc.)				
Village:				
Phone No.:				
Ethnicity:				
Gender:	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female
Birth Date:				
Age:				
Marital Status: (Enter check <input type="checkbox"/> 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:	<input type="checkbox"/>	24 Hour / 7 Day:	<input type="checkbox"/>	14 Day:
	<input type="checkbox"/>	30 Day:	<input type="checkbox"/>	60 Day:
Continued on back?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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<b>NATURE AND EXTENT OF ABUSE</b>	

<b>EMERGENCY ACTION TAKEN:</b>	<input type="checkbox"/> Referred to APS Social Worker on <i>(Enter date &amp; time):</i>

**MAP:**

