



BUREAU OF 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 may be made in person to the Division of Senior Citizens, by phone at (671)735-7415/21 or (671) 632-8853; via email at APSGUAM@dphss.guam.gov; or via facsimile (with cover sheet) at (671) 735-7416

REFERRAL INFORMATION (PLEASE ENSURE GRAY AREAS ARE FILLED OUT COMPLETELY)	
Referral Submitted by:	
Date Submitted:	
Time Submitted:	
Agency (if applicable):	
Phone No.:	
Email Address:	
Referral Received by: (DSC-APS Staff)	
Title:	

CLIENT INFORMATION				
Client Status: (Enter check <input checked="" type="checkbox"/> in appropriate box)	<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)		
	<input type="checkbox"/>	Deceased-Date of Death:		
	<input type="checkbox"/>	Former	<input type="checkbox"/>	New
Last Name:				
First Name:				
Middle Name:				
Address: (Please include directions, description, landmarks, etc.)	<input type="checkbox"/> Map illustrated on sheet #3			
Village:				
Phone No.:				
Email Address:				
Ethnicity:				
Citizenship:				
Birth Date:				
Age:				
Marital Status: (Enter check <input checked="" 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:		

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

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 checked="" 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		
APS Referral No.:		
Central Registry Entered by:		
Date entered into Central Registry:		
Assigned Worker:		
Date Assigned:		
Reports (indicate date completed):	24 Hour / 7 Day:	14 Day:
	30 Day:	60 Day:

MAP:

