



**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:<br>(Enter check <input type="checkbox"/> in appropriate box)  | <input type="checkbox"/> | New                              | <input type="checkbox"/> | Active                  |
|  | <input type="checkbox"/> | Former                           | <input type="checkbox"/> | Deceased;<br>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:<br>(Please include directions, description, landmarks, etc.)<br><input type="checkbox"/> Map on back |                          |                                  |                          |                         |
| Village:   |                          |                                  |                          |                         |
| Current Physical Location:   |                          |                                  |                          |                         |
| Phone No.:   |                          |                                  |                          |                         |
| Ethnicity:   |                          |                                  |                          |                         |
| Citizenship:   |                          |                                  |                          |                         |
| Birth Date:  |                          |                                  |                          |                         |
| Age:   |                          |                                  |                          |                         |
| Marital Status:<br>(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:<br>(Please include directions, description, landmarks, etc.)        |                          |         |                          |          |
| Village:   |                          |         |                          |          |
| Phone No.:   |                          |         |                          |          |
| Ethnicity:   |                          |         |                          |          |
| Gender:  | <input type="checkbox"/> | Male    | <input type="checkbox"/> | Female   |
| Birth Date:  |                          |         |                          |          |
| Age:   |                          |         |                          |          |
| Marital Status:<br>(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      |



**MAP:**

