

Adult Protective Services Referral Form

Date: _____

Person you are referring: _____

Address: _____
(Street) (City) (Apt. #)

Phone: _____ Age of Person: _____

Others Residing in the Home: _____ Relationship to Person: _____

Your Name & Contact Information (this will remain confidential, but we may have additional questions): _____
Name Phone
(Cell) _____

What are your concerns? (Please describe all those things you have observed that make you feel this person is a victim or at risk)

Name of Person's Physician (if known): _____

Please check all of the following that you know about the person you are referring:

- | | |
|--|--|
| <input type="checkbox"/> Can walk without assistance | <input type="checkbox"/> Has guns in the house |
| <input type="checkbox"/> Uses a walker or cane | <input type="checkbox"/> House smells terrible |
| <input type="checkbox"/> Bedfast (cannot get out of bed at all) | <input type="checkbox"/> Hygiene is very poor |
| <input type="checkbox"/> Deaf or hard of hearing | <input type="checkbox"/> Wanders – seems lost |
| <input type="checkbox"/> Hoards – has only a pathway through house | <input type="checkbox"/> Loud quarrels in house |
| <input type="checkbox"/> Someone is stealing from him/her | <input type="checkbox"/> Is physically unable to talk |
| <input type="checkbox"/> Has visible bruises, lacerations | <input type="checkbox"/> Appears to be isolated in house |
| <input type="checkbox"/> Has asked me to summon help | <input type="checkbox"/> New caregiver has moved in |
| <input type="checkbox"/> Has no food in the house | <input type="checkbox"/> Caregiver refuses all visitors |
| <input type="checkbox"/> Has pets that are not being cared for | <input type="checkbox"/> Hazardous conditions in house |

Please fax this referral to: (740) 681-4729, Attention: APS
Or, mail to: APS, 239 W. Main St., Lancaster, OH 43130
To refer by phone: 740.687.6706