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| Office Use Only:  Case Consultation  MDT Case Review  Not Eligible Date Received: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ELDER ABUSE MULTIDISCIPLINARY TEAM REFERRAL FORM** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 1 – Consultation Information (Members Requested)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Adult Protective Services  Attorney General’s Office  Law Enforcement  Financial Institution**  **Ombudsman  Civil Attorney/Legal Services  Medical Practitioner  Other (describe):** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 2 – Referring Agency Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name** | | | | **Last Name** | | | | | | | | | **Email** | | | | | | | **Agency Name** | | | | | | |
| **Office Phone** | | **Office Fax** | | | | | | | | | | **Mobile Phone** | | | | | | | **Supervisor Name** | | | | | | | |
| **Have you made a report to Adult Protective Service (APS) and/or Ombudsman:  Yes  No**  RI law requires you to report suspected abuse, neglect, or financial exploitation | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3 – Client Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name** | | | | | | | **Last Name** | | | | | | | | | | | **DOB** | | | **Age** | | | | | **Gender**  **Select...** |
| **Ethnicity**  **Select...** | | | | | | **Language** | | | | | | | | **Translation/Communication Needs** | | | | | | | | | | | **Marital Status**  **Select...** | |
| **Home Address** | | | | | **City** | | | | | | | | | | **Zip Code** | | | | | | | | | **Telephone** | | |
| **Living Setting**  **Select...** | | | | | | | | | | | **Lives with** | | | | | | | | | | | | | | | |
| **Current Address if Different from Home** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physician Name** | | | | | | | | | | | | | | | | **Physician Telephone** | | | | | | | | | | |
| **Physical Functioning Status: Appears…**  **Select...** | | | | | | | | | **Cognitive Status: Appears…**  **Select...** | | | | | | | | | | | | | **Veteran**  **Yes  No** | | | | |
| **Previous Reports of Abuse:  No  Yes, explain** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4 – Alleged Perpetrator Information (If more than one, please specify in Section 5 under Brief Description)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name** | | | | **Last Name** | | | | | | | | | **Age** | | | | | | | **DOB** | | | | | | |
| **Ethnicity**  **Select...** | **Gender**  **Select...** | | | | | | | | | **Language** | | | | | | | | | **Translation/Communication Needs** | | | | | | | |
| **Relationship to Client** | | | **Primary Caregiver**  **Yes  No** | | | | | | | | **Lives with Client**  **Yes  No** | | | | | | | | **Mental Illness**  **Select... Yes:** | | | | | | | |
| **Address** | | | | | | | | **City** | | | | | | | | | **Zip Code** | | | | | | **Telephone** | | | |
| **Section 5 – Abuse Information** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of Abuse (Check all that apply)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical Abuse  Sexual Abuse  Neglect  Abandonment**  **Emotional Abuse  Isolation  Self-Neglect  Financial Exploitation** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Agencies Involved** | | | | | | | | | | | | | **Others with Knowledge of Abuse** | | | | | | | | | | | | | |
| **Brief Description of abuse and any other concerns (attach additional pages if necessary)** | | | | | | | | | | | | | | | | | | | | | | | | | | |