EXECUTIVE OFFICE OF ELDER AFFAIRS
COMMONWEALTH OF MASSACHUSETTS

ELDER ABUSE MANDATED REPORTER FORM

Per M.G.L. c. 19A, this form should be returned within 48 hours of the oral report, to the following Designated Protective Service Agency:

Springwell
307 Waverley Oaks Rd Suite 205
Waltham, MA 02452
Fax: 617-926-9783

Reporter Information:

Name: _____ **Occupation:** _____
Agency: _____ **Address:** _____
Tel. #: _____ _____

Information about Elder Being Allegedly Abused/Neglected:

Name: _____
Address: _____
Permanent: _____
Temporary: _____
Tel. #: _____
Approximate Age: _____ **Sex:** _____ **Preferred Language:** _____
Is the elder aware a report is being made? _____ **Is English spoken?**

Description of alleged abuse incidents and/or condition of neglect: Include name, dates, times, and specific facts and any information regarding prior incidents of abuse/neglect.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Persons or Agencies Involved or Knowledgeable about Elder:

Name _____ **Age** _____ **Relationship** _____
Address _____ **Phone** _____

Name _____ **Age** _____ **Relationship** _____
Address _____ **Phone** _____

Name _____ **Age** _____ **Relationship** _____
Address _____ **Phone** _____

Name _____ **Age** _____ **Relationship** _____
Address _____ **Phone** _____

Name _____ **Age** _____ **Relationship** _____
Address _____ **Phone** _____

_____

Is medical treatment required immediately? **Yes** ____ **No** ____ **Possibly** ____
Describe treatment needed or already received: _____
_____
_____
_____

Does the reporter believe the situation constitutes an emergency?
Yes ___ **No** ____ **Possibly** ____

Describe the risk of death or immediate and serious harm: _____
_____
_____
_____

Additional information or comments:
_____
_____
_____
_____
_____
_____

_____
Signature of Reporter **Date**