



## A Safe Haven For Adolescent Mothers Ltd. (ASHFAM) Referral Form

Referral Date \_\_\_\_\_

Do you know someone who is need of or could benefit from ASHFAM's Programs and Outreach Services? No \_\_\_\_\_ Yes \_\_\_\_\_

Are they under the age of 25? No \_\_\_\_\_ Yes \_\_\_\_\_

Are they a single parent? No \_\_\_\_\_ Yes \_\_\_\_\_  
Single Mom \_\_\_\_\_ Dad \_\_\_\_\_

Would the adolescent Mother benefit from or require temporary housing?  
No \_\_\_\_\_ Yes \_\_\_\_\_

Would the single parent benefit from our External Outreach Services?  
No \_\_\_\_\_ Yes \_\_\_\_\_

Are they a young couple under the age of 25? No \_\_\_\_\_ Yes \_\_\_\_\_

### **Please provide contact information of referred candidates below:**

Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Age(s): \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

E-mail: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Currently Pregnant: \_\_\_\_\_