



GENESISTER PROGRAM REFERRAL

To participate in GENESISTER, the youth must be:

- ✓ Female
- ✓ Between the age of 12 & 17
- ✓ A sibling of a pregnant teen or teen parent (a teen aunt)
- ✓ A daughter of a teen parent
- ✓ A current Boulder County resident

Please provide as much of the following information as possible.

REFERRAL INFORMATION - The person making the referral

Name: _____ Phone: _____
 Referring Agency/Relationship: _____ Date: _____

YOUTH INFORMATION - The person being referred

Name: _____ DOB: _____ Age: _____
 Address: _____ City: _____
 School: _____ Current Grade: _____

FAMILY INFORMATION- If parents/guardians are unknown/unavailable, please provide another family contact.

Parent's/Guardian's Name: _____
 Language of choice: _____
 Phone: _____ Other: _____

NAME OF TEEN PARENT/SIBLING (if applicable): _____

AGE SIBLING BECAME PREGNANT (if applicable): _____

ADDITIONAL INFORMATION:

PLEASE RETURN THIS REFERRAL FORM TO:

Fax: 303.413.7505, Attn: Maya Sol Dansie Mail: GENESISTER, 3482 Broadway, Boulder, CO 80304

For questions or more information, please call 303.678.6139

-----STAFF USE ONLY -----



Date Received: _____ RDB#: _____ Assigned To: _____