Highfields Referral Registration

Client Information:

Name of Youth: _____ DOB: _____

Home Address: _____ Parent/Guardian: _____
_____ Phone Number: _____
_____ Relationship: _____

Preferred Pronouns: _____ Sex Assigned at Birth: _____

Is there a history of victimization? ☐ Yes ☐ No

Is there a history of perpetration? ☐ Yes ☐ No

Check all that apply: ☐ Neglect ☐ Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse

Medical Information:

Allergies: _____ Special Medical Needs: _____
_____ _____
_____ _____

Prescribed Medications: _____ Prescribed Medications: _____
_____ _____
_____ _____
_____ _____

Education Information:

Last School Attended: _____ Grade: _____

Current IEP: ☐ Yes ☐ No Classification: _____

Referral Source:

Worker Name: _____ Worker's Phone: _____

Agency Name: _____ Worker's Email: _____
Agency Address: _____
_____