! EMERGENCY / URGENT CARE NOTICE

If the client is in immediate danger or experiencing a psychiatric emergency, do not use this form. Please call 911 or take the client to the nearest emergency room immediately.
For urgent (non-emergency) referrals requiring a response within 48 hours, please mark Urgency as Urgent in Section 3 and call our intake line directly: (202) 840-0423.

Referral Form

1647 Benning Road NE, Suite 301, Washington DC 20002
(202) 840-0423 | info@starfishhealth.com | StarFishHealth.com

StarFish Health
Wellness, one step at a time.

About Starfish Health

Starfish Health Inc. is a Medicaid-certified outpatient behavioral health organization. We provide therapy, psychiatric care, medication management, and coordinated community support.

Currently accepting referrals for: Washington, DC.

We accept multiple insurance plans, including Medicaid. See our full list of accepted plans and current eligibility at starfishhealth.com/insurance-payment.

Areas we help with:

- Mental Health Needs, including depression, anxiety, trauma, PTSD, and mood disorders
- Substance Use Needs, including alcohol and drug dependency
- Co-occurring Needs, where mental health and substance use overlap
- Recovery & Life Challenges, including housing instability, reentry, and high-stress life situations

* = required field

1. Client Information

***Full name (client)**

***Date of birth** *(DD/MM/YYYY)*

Is the client a minor (under 18)?
◯ Yes ◯ No

If yes, complete the Parent / Guardian Information below.

Parent / Guardian full name *(required if client is a minor)*

Parent / Guardian phone number *(required if client is a minor)*

Parent / Guardian email address *(required if client is a minor)*

Member ID/policy number *(optional, if known)*

Insurance provider *(check one)*
◯ Aetna ◯ AmeriHealth ◯ CareFirst BCBS ◯ Medicaid ◯ Medicare
◯ WellPoint ◯ Other / Not sure

Gender *(optional)*

***Address**

***City / State / ZIP**

***Phone number** *((000) 000-0000)*

***Email address** *(example@example.com)*

***Preferred contact method**
◯ Phone call ◯ Text message ◯ Email

2. Referring Party

If this is a self-referral, please write N/A in the agency and case manager fields and select Self-referral below.

Agency name *(N/A if self-referral)*

Case manager name / role

Phone number *((000) 000-0000)*

Email address *(example@example.com)*

***Date of referral** *(DD/MM/YYYY)*

***Referral source**
◯ Agency / case manager ◯ Self-referral ◯ Website ◯ Word of mouth ◯ Community organization ◯ Other

3. Reason for Referral

Please check all that apply. Do not include DSM diagnostic codes; these are recorded in confidential clinical documentation and determined by our clinicians during assessment.

***Presenting needs**
☐ Mental Health Needs ☐ Trauma or PTSD ☐ Substance Use Needs ☐ Co-occurring Needs ☐ Crisis stabilization
☐ Case management and care coordination ☐ Reentry / justice support ☐ Other

***Urgency**
◯ Routine ◯ Urgent (response within 48 hours)
◯ N/A — self-referral

Additional notes

4. Authorization and Consent

I, the undersigned, authorize Starfish Health Inc. to provide behavioral health services and share relevant information with the referring case manager for care coordination, in accordance with HIPAA regulations. If the client is a minor, this authorization must be signed by a parent or legal guardian.

Case manager signature *(N/A if self-referral)*

Parent / Guardian signature *(required if client is a minor)*

Date *(DD/MM/YYYY)*

For Office Use Only

Intake date *(DD/MM/YYYY)*

Assigned clinician

Notes