



headspace Albury Wodonga
155 High Street Wodonga Victoria 3690
email: headspaceAW@gatewayhealth.org.au

headspace Wangaratta
44 Rowan Street Wangaratta Victoria 3677
email: headspaceAW@gatewayhealth.org.au

Phone: 1300 332 022 Fax: 02 6024 5792



Referral Information

headspace is a free service for young people aged **12-25 years**. headspace Albury Wodonga and headspace Wangaratta are programs of lead agency **Gateway Health**, supporting young people and their families across the community.

We provide a range of services, including mental health and wellbeing support, alcohol and other drug support, physical and sexual health (via Gateway Health Medical Practice and Clinic 35), work and study support, community engagement, education and awareness, cultural connections coordination, non-therapeutic social groups, and sexuality and gender support.

PLEASE NOTE: headspace Albury Wodonga and headspace Wangaratta are not an acute mental health/crisis service. For opening hours, please visit our website for Wodonga or Wangaratta.

If you have any immediate concerns regarding the safety and wellbeing of a young person, please contact one of the following services for assistance:

Mental Health Triage Service -
1300 104 211

Lifeline -
13 11 14

Kids Helpline -
1800 551 800

Please be advised headspace services are for young people between the ages of 12-25. You can access similar services through other Gateway Health services:

- Child & Family Health counselling services for young people under 12yrs - **02 6022 8888**
- Head to Health mental health supports for people over 25 - **1800 657 573**

In an emergency, please call 000 immediately.

Young people can refer themselves directly to headspace Albury Wodonga or headspace Wangaratta, they don't need anyone else to do it for them.

If the young person prefers, a family member, carer, friend, GP, school, or another service can make the referral as long as they know about it and have given their consent.

For young people under 16, parent or guardian consent is required. If gaining consent is difficult, please contact us by phone, email, or by visiting the centre so we can talk through alternative options.

Referrals can be made by:

- Visiting the centre (our staff can assist with completing the form)
- Calling 1300 332 022
- Emailing a completed referral form to headspaceaw@gatewayhealth.org.au

After the Referral

Once we receive the referral, our staff will contact the young person (or their parent/carer, if appropriate) within **2 business days** to book a phone intake. We aim to schedule this intake within **two weeks** of first making contact.

We follow a “**no wrong door**” policy. If the young person decides another service is a better fit after their phone intake, our clinicians will support them with a warm referral, so they feel supported throughout the process.

If you are completing this referral on behalf of the young person, you will be notified once a service option has been chosen, or if we close the referral because we were unable to reach the young person.

If the young person referred themselves, we will notify them directly if the referral is closed due to no response.

Information for Services

If you are a referring service and would like more information on headspace Albury Wodonga and Wangaratta, referral pathway and information on other local services, [please check out this website](#).



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Referral Form

headspace Albury Wodonga and headspace Wangaratta is a voluntary service for young people aged 12-25 years of age. headspace can only engage if you have consented to this referral.

If wanting to refer without parent or legal guardian consent under 16 years of age, please call our office on 1300 332 022 to discuss.

Please ensure all sections are completed and legible.

Date of Referral			
Has the young person consented to the referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is the young person aged between 12-25 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If the young person is under 16 years of age, have the parents or legal guardian of the young person consented to the referral? Please provide name and number of persons consenting below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Consent provided by		Contact Number	
Relationship to young person			
Details of Young Person			
Surname		Legal/Given Name	
Preferred Pronoun/s		Preferred/Aligned Name	
Date of Birth		Sex Assigned at Birth	
Gender Identity		Email Address	
Phone Number		Preferred Method of Communication?	<input type="checkbox"/> Phone <input type="checkbox"/> Mobile
Mobile Number			<input type="checkbox"/> Email <input type="checkbox"/> SMS
Residential Address (Include Suburb & Postcode)		First Nations Identity	
Country of Birth		Nationality	
Preferred Language		Interpreter Needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare Number & Reference Number		Expiry Date	
Centrelink Payment Type (If applicable)			
Which location would the young person prefer to have the appointments booked at?	<input type="checkbox"/> Wodonga	<input type="checkbox"/> Wangaratta	
Emergency Contact (please make sure this section is completed)			
Full Name		Relationship to young person	
Address (Include Suburb & Postcode)		Contact Number/s	
		Email	
Details of Referrer (please make sure this section is completed)			
Full Name		Relationship to young person	
Organisation		Contact Number/s	
Address		Email	



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Reason/s for Referral			
<input type="checkbox"/> Mental Health & Wellbeing	<input type="checkbox"/> General or Sexual Health	<input type="checkbox"/> Alcohol & other Drugs*	<input type="checkbox"/> Work & Study pathways
<input type="checkbox"/> Other			
*If Alcohol and Other Drugs referral, please provide the following information:			
Substance/s Used		Frequency/Amount	
		Intravenous (IV) Use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Young Persons Diagnoses or Concerns (tick all that apply)			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Trauma/PTSD	<input type="checkbox"/> Eating Concerns
<input type="checkbox"/> Psychosis/Hallucinations	<input type="checkbox"/> Mood Disorder/Bipolar	<input type="checkbox"/> Behavioural Concerns	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Self-harm	<input type="checkbox"/> Substance Use Concerns	<input type="checkbox"/> Learning/Intellectual Disability	
<input type="checkbox"/> ADHD	<input type="checkbox"/> Autism	<input type="checkbox"/> School Refusal /Disengagement	
<input type="checkbox"/> Family conflict	<input type="checkbox"/> Sleep concerns	<input type="checkbox"/> Chronic Pain/Medical issues affecting mental health	
<input type="checkbox"/> Housing Instability	<input type="checkbox"/> Other (please specify)		
Relevant History (please include prescribed medications and any other relevant information)			
Additional Information supplied/attached?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Service History and Other Information (please provide information on other services, court orders (if applicable) and General Practitioner)			
Do you currently see any other services? If yes, please tick appropriate box/boxes			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Drug & Alcohol	<input type="checkbox"/> School/Other Counsellor	<input type="checkbox"/> Community Services	<input type="checkbox"/> Child Protection
<input type="checkbox"/> CAMHS/NECAMHS	<input type="checkbox"/> Adult Mental Health	<input type="checkbox"/> Youth/Juvenile Justice	<input type="checkbox"/> NDIS
<input type="checkbox"/> Other (please specify)			
Is the other service aware of the referral to headspace?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the services involved continue working with you?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any Court Orders we may need to keep in mind while supporting? If yes, please specify			<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Family Court Orders	<input type="checkbox"/> IVO	<input type="checkbox"/> AVO	<input type="checkbox"/> Other, detail below
Do you have a regular GP? If yes, please provide details below			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of GP		Name of Clinic	
Address (if known)		Contact Number/s	
What do you hope headspace can support the young person with?			



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If you are a service referring following working with the young person - what interventions have been provided to the young person prior to the referral to headspace?