



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. If you have any immediate concerns regarding the safety and wellbeing for yourself or someone else, please contact one of the following services for assistance:

Mental Health Triage Service -
1300 104 211

Lifeline -
13 11 14

Kids Helpline -
1800 55 1800

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.

You can reach out to headspace Albury Wodonga or headspace Wangaratta yourself; you don't need anyone else to do it for you.

If you'd prefer, a family member, carer, friend, GP, school, or another service can make the referral for you, as long as you know about it and give your consent.

If you're under 16, we'll need consent from a parent or guardian. If that's tricky, just get in touch with us by phone, email, or drop into the centre and we'll chat about other options together.

You can refer by visiting the centre (our staff can help you fill out the form), calling **1300 332 022**, or emailing your referral form to headspaceaw@gatewayhealth.org.au.

For centre opening hours, please visit our website:

- Wodonga - headspace.org.au/albury-wodonga
- Wangaratta - headspace.org.au/wangaratta

What happens next?

Once we receive your referral, our team will contact you (or your parent/carer if that's who we need to speak with) within **2 business days** to book a phone intake appointment. We aim to have that phone intake happen within **two weeks** of reaching out.

We'll try a few times to get in touch to book your intake. If we don't hear back, we'll send you a text letting you know when to contact us by if you would like headspace support at this time. If you change your mind later that's totally okay. You can refer again at any time.

We follow a "**no wrong door**" approach, which means you don't have to worry about picking the "right" service straight away. If, after your phone intake, you decide another service feels like a better fit, our clinicians can support you with a referral so you're not navigating things on your own.

If someone else referred you, we'll let them know once you've chosen your service option, or if we need to close the referral because we weren't able to reach you.

If you referred yourself, we'll only contact you, and we'll let you know if your referral is closed due to no response.



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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			
Do you consent to this referral?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you aged between 12-25 years of age?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you are under 16 years of age, have your parents or legal guardian 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 you			
Your Details			
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 you	
Address (Include Suburb & Postcode)		Contact Number/s	
		Email	



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
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
Relevant History (please include prescribed medications and any other relevant information)			
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)			
Service Name			
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 with?			