niagarahealth
Extraordinary Caring. Every Person. Every Time.

New Port Centre 260 Sugarloaf Street, Port Colborne, ON, L3K 2N7
Phone: (905) 378-4647 Ext. 32500 • Fax: (905) 834-3002
Email: NewPortAdmin@niagarahealth.on.ca
Web: https://www.niagarahealth.on.ca/site/new-port-centre

Client Name: _____

DOB: _____
(dd/mm/yyyy)

ADMISSION INFORMATION

Thank you for considering an application to New Port Centre for your client. We are a **non-smoking facility**. We accept individuals on Opiate Replacement Therapy. Below is a list of the necessary materials needed for a completed referral package. Please ensure all documents are labeled with client's full name and DOB to ensure case tracking.

New Port Centre Pre-Referral Needs Assessment (4 pages) _____

New Port Center Intake Form (2 Pages) _____

Legal History Form _____

E-Mail/Text Communication Consent Form _____

Transition Plan _____

Medical Profile Completed by Health Practitioner (2 Pages) _____

Photocopy of Valid OHIP Card _____

All New Port Centre forms, general information, photos and FAQ are available on the New Port Centre website at: https://www.niagarahealth.on.ca/site/new-port-centre

New Port Centre Admission Criteria

- New Port Centre asks that individuals that have pending charges for violent offenses have their charges resolved before applying. The intake coordinator will review history of violent offences prior to a potential acceptance into the program. New Port does not accept referrals from individuals in custody. Those on the sexual offender's registry will not be accepted into New Port Centre.
- New Port Centre encourages those presenting with no fixed address to have their housing issues resolved prior to applying. The transition plan in the intake package needs to be completed and will be reviewed with intake coordinator.
- New Port Centre asks that those who have previously attended the program wait four months before reapplying following their most recent discharge. The pre-referral assessment, intake package and medical will be required to be completed again when reapplying with an alcohol/drug treatment provider.

Questions and/or concerns can be directed to our Intake Coordinator at 905-378-4647 ext. 32524 Monday to Friday between the hours of 8am to 4pm.

Please fax completed forms to the Intake Coordinator at 905-834-3002.

Please inform your client that our Intake Coordinator will be contacting them prior to admission for an intake interview. Your client will be expected to keep in contact with New Port Centre weekly once receiving a bed date.

New Port Centre Pre-Referral Needs Assessment

Must be completed in full by referring counsellor

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Client Name:	Gender:	Age:
Current Housing Situation:		

Referral Agent:	Referral Agent Signature:
Referral Agency:	Date Completed:

Section One: Pre-screening	1	2	3
Have you attended New Port Centre in the last twelve months? If so, how many times?	☐	☐	☐

	Yes	No
1. Are you willing to attend treatment in a co-ed residential setting?	☐	☐
2. Are you willing to abstain for smoking and/or vaping for the 21-day treatment stay?	☐	☐
3. Are you willing to attend daily scheduled workshops and groups (4 per day)?	☐	☐
4. Are you willing to share a bedroom while in treatment?	☐	☐
5. Are you willing to attend a pre-treatment stay at detox if recommended by the intake team?	☐	☐
6. Are you willing to take medications as prescribed, at our scheduled times (08:00, 12:00, 16:00, 21:00)?	☐	☐
7. Do you currently have any pending legal charges for a violent offense?	☐	☐

Please provide additional information as-needed:

If client has attended New Port Centre more than twice within the last 12-month period, it is recommended that client consider an alternative treatment centre option.
If client has answered "No" to questions 1-6, or "Yes" to question 7, please assess whether New Port Centre would an appropriate treatment option for your client.

Brief Client Summary (contributing factors, history of other substances, length of use, etc.)

Client Stated Treatment Goals

My goal is…
My motivation is…

Section A – Client Reported Substance Use History

Substance	Used in the past 12 months?			# of days used in last 90 days	Typical amount used each day	Clinical Comments (ex. Age of first use, patterns, periods of abstinence, etc.)	Motivated To Quit? (Check if Yes)
	Yes	No	Refused				
Alcohol	☐	☐	☐				☐
Crack/Cocaine	☐	☐	☐				☐
Amphetamines/Other Stimulants	☐	☐	☐				☐
Cannabis	☐	☐	☐				☐
Benzodiazepines	☐	☐	☐				☐
Barbiturates	☐	☐	☐				☐
Heroin/Opium	☐	☐	☐				☐
Prescription Opioids	☐	☐	☐				☐
Over-The-Counter Codeine Preparations	☐	☐	☐				☐
Hallucinogens	☐	☐	☐				☐
Glue/Inhalants	☐	☐	☐				☐
Tobacco/Nicotine	☐	☐	☐				☐

Section B – Client Identified Areas of Concern

	Yes	No	Brief Comments
Trauma/Grief (ex. traumatic events, significant losses)	☐	☐	
Housing Concerns	☐	☐	
History Of Seizures (medical or withdrawal)	☐	☐	
Falls Risk (ex. mobility)	☐	☐	
Learning Difficulties	☐	☐	
Eating Concerns	☐	☐	
Brain Injury	☐	☐	
Sleep Concerns	☐	☐	
Personal Care (bathing, eating)			

Additional information and comments for Section B

Section C - Perceived Social Supports

Please include information about social supports as indicated by client: (ex. family, friends, worker, etc.)

Relationship Concerns (please check and discuss if indicated by client): ☐ Parents ☐ Siblings ☐ Partner ☐ Children ☐ Friends

Section D

Clinical Comments and Recommendations

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INTAKE FORM

This form must be completed by referring agents only

Client First Name:	**Last Name at Birth:**
Client Last Name:	**DOB:** *(DD-MM-YYYY)*
Gender: **Pronoun(s):**	**Next of Kin:** **Relationship:** **Next of Kin Phone #:**
Contact Phone #:	
Address: **Apt.**	**Relationship Status:** ☐Single ☐Widowed ☐Separated/Divorced ☐Married/Common-law/Partner
City, Province:	
Postal Code:	**Employment Status:** ☐ Employed/Self Employed ☐ Full-time ☐ Part-time ☐ Unemployed ☐Student/retraining ☐ Disabled ☐ Retired ☐ Not in labour force
Health Card#: **Ver:**	
Pharmacy: **Phone #:**	
Telephone call allowed: ☐ Yes / ☐ No **Message allowed:** ☐ Yes / ☐ No	**Income Source:** ☐ Employment ☐ ODSP ☐ Ontario Works ☐ Disability Ins. ☐ Employment Ins. ☐ None ☐ Retired ☐ Other Ins. ☐ Family ☐ Other
Highest Education: ☐No Formal Education ☐Some Primary ☐Primary ☐Some Secondary/High School ☐Secondary/High School ☐Some College ☐Completed College ☐Some University ☐University Degree	**Ethnicity:**
Literacy concerns: ☐Yes ☐No ***If yes please include grade level*** _____ **Learning Difficulties:** ☐Yes ☐No ***If yes please expand:***_____	**What is your mother tongue?** _____ **In which of Canada's Official Languages are you most comfortable receiving your healthcare services?** ☐ English ☐ French **In which language are you most comfortable receiving your healthcare services?** _____
Legal Issues: ☐ None ☐ Awaiting Trial/Sentencing ☐ Probation ☐ Parole ☐ Incarcerated ☐ Other	

Required/Mandated Admission:
☐ None ☐ Choice between Treatment or Jail ☐ Condition of Probation/Parole ☐ Child/Welfare
☐ Condition of Employment ☐ Condition of Family ☐ Other

Young Offender:
☐ Yes / ☐ No

Current Problem Substance(s)		**# Days used in Last 30 days**
1.		
2.		
3.		
4.		
5.		

Substances Used in Last Year (***check all that apply***)

☐ None	☐ Ecstasy
☐ Alcohol	☐ Fentanyl
☐ Barbiturates	☐ Glue / Inhalants
☐ Benzodiazepines	☐ Hallucinogens
☐ Cannabis	☐ Heroin / Opium
☐ Cocaine	☐ Other Psychoactives
☐ Crack	☐ Prescription Opioids
☐ Crystal meth	☐ Steroids
	☐ Tobacco

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INTAKE FORM

This form must be completed by referring agents only

HEALTH HISTORY

Family Doctor:	Yes	No	
Dr. Phone #: ( )	☐	☐	**Taking Methadone/Suboxone**
Psychiatrist:	☐	☐	**Visual Impairment**
Psychiatrist Phone #: ( )	☐	☐	**Hearing Impairment**
Physical Health	☐	☐	**Mobility/Physical Impairment**
_____ # of overnight hospitalization(s) for physical issues in the last year	☐	☐	**Pregnant**
Dates of Hospitalization(s): _____	☐	☐	**Gambling Problem**
Reason for Hospitalization: _____			

Non-medical Injection Drug Use (Check (✓) one)

☐ **Never Injected** ☐ **Injected Prior to 1 Year Ago** ☐ **Injected in Last Year**

MENTAL HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	**Diagnosed - Now**	☐	☐	**Diagnosed in Lifetime**
☐	☐	**Hospitalized – Last Year**	☐	☐	**Hospitalized in Lifetime**
☐	☐	**Counselling/Support/Tx – Now**	☐	☐	**Counselling/Support/Tx in Last year**
☐	☐	**Counselling/Support/Tx – Ever**	☐	☐	**Prescribed Medication – Now**
☐	☐	**Prescribed Medication in Last Year**	☐	☐	**Prescribed Medication - Ever**

☐	☐	**Threat to Self**	☐ **In past 30 days**	☐ **In past year**	☐ **In Lifetime**
☐	☐	**Attempted Suicide**	☐ **In past 30 days**	☐ **In past year**	☐ **In Lifetime**
☐	☐	**Risk of Violence**	☐ **In past 30 days**	☐ **In past year**	☐ **In Lifetime**
☐	☐	**Traumatic Event**	☐ **In past 30 days**	☐ **In past year**	☐ **In Lifetime**
☐	☐	**Verbally or Physically Threatening**			
☐	☐	**Attacking with Objects**			
☐	☐	**Disruptive – easily angered, shouts, confused, irritable**			
☐	☐	**History of code white/aggressive behaviour in clinical scenario**			

Referral Agency: _____ **Phone #: (** **)** _____ **Ext.**_____ **Fax #: (** **)** _____

Referring Agent Name: (Print)_____ **Agent Signature:** _____

Date Referral Completed: _____ **Date Referral Faxed:** _____
(dd/mm/yyyy) (dd/mm/yyyy)

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L E G A L H I S T O R Y F O R M

Have you ever been charged with a Federal or Provincial Offence?

Yes _____ No_____

If Yes, please indicate the date and describe the offence and outcome.

Date	Offence (Charge)	Outcome

Are you presently on Probation or Parole? Yes _____ No _____

If Yes: Name of Probation/Parole Officer: _____

Start Date_____ Expected End Date_____

Contact your Probation/Parole Officer to complete a consent form to allow the New Port Centre to confirm your attendance and fax it to the New Port Centre at 905-834-3002.

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E–Mail/Text Communication Consent Form

I understand that e-mail/text is not a secure method of communication and therefore Niagara Health (NH) cannot guarantee the security and confidentiality of messages/texts sent and received and will not be liable for improper disclosure of confidential information sent by this method between the hospital and myself.

I understand that information contained in e-mail/text messages will become the property of Niagara Health.

I understand that information contained in e-mail/text message may be personal health information and will be retained on my health record.

I understand that NH staff only use and access e-mail and text during regular business hours and day. Any text/e-mail received after hours will not be responded to until the next business day.

I understand that the Information and Privacy Commissioner (IPC) Ontario, does not support the practice of communicating personal health information by e-mail/text.

I understand that I will not use e-mail/text to communicate any time sensitive matters or medical emergencies with my health care provider.

I understand that I am responsible for advising the hospital of any changes to my e-mail address or my phone number that I have provided for this purpose.

I understand that if I no longer wish to receive e-mails/texts communication I will advise a member of my health care team in writing.

I understand that NH reserves the right to withdraw communicating by e-mail/text at any time.

I agree to the information regarding admission to the New Port Centre being contained in e-mail/text communications.

I have read the above information carefully. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

I agree to correspond with NH via: ☐ **Email** _____

☐ **Text** _____

Patient Name: _____

Signature of Patient: _____

Date: _____
dd/mm/yyyy

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TRANSITION PLAN

Due to the short nature of the New Port Centre Residential Treatment Program, we are unable to address housing concerns during your stay. If you are struggling with stable, supportive housing we encourage you to resolve this before attending the program.

New Port Centre is not financially responsible for transportation to or from treatment.

Public Transit options around Niagara Region for Port Colborne can be found at https://www.niagararegion.ca/transit/

Please provide a transition plan for the end of your treatment stay whether at the end of the 21-day treatment cycle or earlier. If possible, please provide the phone number of someone to contact in case of an unplanned transition.

Name:_____Relationship:_____
Contact #:_____

Name:_____Relationship:_____
Contact #:_____

Plan:_____
_____
_____
_____
_____
_____
_____