Affix patient label here

New Port Centre
Niagara Health System, Port Colborne Site, 260 Sugarloaf St. Port Colborne ON
Phone: 905-834-4501 Ext. 32500 Fax 905 834 3002

Medical History: Please have this form completed by your health care provider

Name: _____ DOB: _____

1) **Substance(s) use**: Please briefly outline the substance(s) and pattern of use that has prompted this referral

_____

_____

_____

_____

2) **Allergies:** No Known Allergies ☐

If yes please specify:

Allergan	Response

3) **Diet:** Does your client/patient require a special diet? No ☐ Yes ☐
If so please specify:

4) **Immunization History:** (Note: Immunizations are not mandatory for admission)
Which of the following immunizations has your client/patient received?

						Comments
Tetanus	Yes ☐	Year _____	No ☐	Unknown ☐		
Hepatitis A Series	Yes ☐	Year _____	No ☐	Unknown ☐		
Hepatitis B Series	Yes ☐	Year _____	No ☐	Unknown ☐		

5) **Screening History :** (Note: Screening is not mandatory for admission)

					Comments/Results
Hepatitis B	Yes ☐	Year _____	No ☐	Unknown ☐	
Hepatitis C	Yes ☐	Year _____	No ☐	Unknown ☐	
HIV	Yes ☐	Year _____	No ☐	Unknown ☐	

6) **Smoking**: New Port is a non smoking program. (Clients are required to bring an eighteen day supply of a smoking cessation aid if required)

Non Smoker ☐ Smoker ☐ Number/Day? _____

7) Mental Health: Does the client/patient have a history of mental health diagnoses?

No ☐ Unknown ☐ Yes ☐ If yes please specify: _____

_____

_____

New Port has an affiliated psychiatrist available for consult. Please indicate if you would like your client/patient to have an appointment with the psychiatrist. If yes then please briefly outline the relevant history and the objectives of the consult. A copy of the consult will be sent to the ordering provider.

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_____

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_____

Provider Name _____ Billing Number _____

8) **Medications:** Please List all medications that your client is currently prescribed

Medication	Dose	Frequency

9) **Health**: Please list any medical information including acute or chronic disorders, physical limitations etc.

_____

_____

_____

_____

Provider Signature	Office Stamp
Print Name	
Client/Patient Signature	
Date:	