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: www.niagarahealth.on.ca/site/mental-health-addictions

**Client Name:** ___________

**DOB:** __________
(dd/mm/yyyy)

Dear Doctor/Nurse Practitioner:

Your patient has applied for admission to the residential component for treatment of their addiction at the New Port Centre. We request a thorough and accurate completion of the attached Medical Profile to ensure that it is consistent with the medications that the client is currently prescribed. The New Port Centre offers medical services through a Nurse Practitioner. The New Port addiction counsellors are available 24 hours per day however they are non-medical personnel.

All other medications the client will need for the 21-day treatment should arrive with the patient, blister packed and in their original packaging. If needed, please contact Boggio Pharmacy prior to client's admission to have the prescriptions filled and delivered to the New Port Centre on client's admission day. Clients are responsible to bring all Nicotine Replacement Therapy, and may also bring any non-prescribed medications in a sealed/unopened container (please see list).

| | May Bring | Do Not Bring |
|---|---|---|
| For Pain | Acetaminophen(Tylenol), Ibuprofen(Advil), Naproxen | Combination meds such as "Cold and Sinus" or "Night Time". Anything containing Benadryl or Pseudoephedrine |
| For Sleep | Melatonin | "Sleep Eze" "Nyquil" |
| Nicotine Replacement Therapy | Patches, gum, lozenges, inhalers, sprays or prescribed medications | Vapes, e-cigarettes, cannabis, tobacco |
| For Allergies | Claritin, Aerius or Reactin | Sudafed or Benadryl |
| Heartburn/ Stomach Issues | Pepto Bismol, Tums | Gravol, Imodium or Lomotil |
| Vitamins/ Supplements | Original containers, Ensure or Boost | *Protein powder and supplements require Nurse Practitioner's approval |

Clients who are prescribed **Opiate Replacement Therapy** should have their information and prescription faxed to Boggio Pharmacy in Port Colborne. Boggio Pharmacy will be delivering Opiate Replacement Therapy, including Methadone and Suboxone, each morning throughout the client's admission. ****Please prescribe carries for the Pharmacy on days they are closed****

**Boggio Pharmacy**
**200 Catharine Street**
**Port Colborne, On L3K 4K8**

**Phone: 905-834-3514**
**Fax: 905-834-6252**

If you have any questions, please contact the Nurse Practitioner at 905-378-4647 ext. 32516. Thank you for your cooperation.

 Revised March 2023

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(dd/mm/yyyy)

# M E D I C A L   P R O F I L E

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

**NAME:** ____________________________ **DOB:** ___________________ **OHIP #:** ______________________
(dd/mm/yyyy)

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:

| Allergen | 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 21-day supply of smoking cessation aid if required)
   Non Smoker ☐ Smoker ☐ Number/Day? _______________________

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# MEDICAL PROFILE

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.

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Provider Name: ________________________________ Billing Number: _________________________

8. **Medications:** Please list all medications that your client/patient 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:** (dd/mm/yyyy) | |



Revised March 2023