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.

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.

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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:** _____ (dd/mm/yyyy) **OHIP #:** _____

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? _____

Revised May 2022

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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 May 2022