niagarahealth
Extraordinary Caring. Every Person. Every Time.

New Port Centre

NIAGARA HEALTH • PORT COLBORNE GENERAL SITE
260 Sugarloaf Street, Port Colborne, ON L3K 2N7 • Phone (905) 378-4647 Ext 32500 • Fax: (905) 834-3002
E-mail: NewPortAdmin@niagarahealth.on.ca • Web: www.niagarahealth.on.ca/site/mental-health-addictions

Dear Doctor/Nurse Practitioner:

Your patient has applied for admission to the residential component for treatment of his/her addiction(s) at the New Port Centre. We request a thorough and accurate completion of the enclosed Medical Profile to ensure that it is consistent with the medications that the client has been prescribed. New Port offers medical services through an onsite Nurse Practitioner and physician consult during weekdays. New Port addiction counsellors are available 24 hours per day however they are non-medical personnel.

Our program has an affiliated psychiatric consultation service through the Ontario Telemedicine Network (OTN). If you would like your patient to receive an OTN Psychiatric Consultation, please complete the enclosed Central Access to Psychiatric Services Form (2 pages CAPS Form) and fax it to the New Port Centre along with the medical profile.

Clients are responsible to bring all needed medication, NRT and may also bring any non-prescribed medications (please see list).

We appreciate your cooperation in completing these forms accurately and in full in order to facilitate the admission and care of your patient.

Many thanks for your attention to these vital safety issues.

Sincerely,

Management,
New Port Centre

Please do not send personal health information by E-mail. E-mail is not secure.

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Client Name: _____
DOB: _____ (dd/mm/yyyy)

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Affix Client Label

MEDICAL PROFILE

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 18-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: APRIL 2019

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Adult Outpatient Mental Health Referral Form

Pages 1 and 2 must be completed in full for *all* referrals (incomplete forms *will not* be processed)
Additional required information form must be completed for all ECT, rTMS and Medication Clinic referrals
Please fax all referrals to 905.704.4420. For any enquiries, please call Intake at 905.378.4647 ext. 49613

SECTION A: CLIENT INFORMATION – is client aware of referral? ☐Yes ☐No

Client Name: _____ HC with Version Code: _____
Address: _____ City/Town: _____
Telephone: (H) _____ leave message Y ☐ N ☐ (C) _____ leave message Y ☐ N ☐
Date of Birth: _____ Birth Gender: ☐Female ☐Male Identified Gender: _____
Name of Family Physician: _____ Phone number: _____
Psychiatrist: _____ Phone number: _____

SECTION B: Program Requested:	**Reason for Referral:**	**Internal Use Only:**
☐ CAPS - Centralized Access to Psychiatric Services / Consultation	☐ Assessment ☐ Diagnostic Clarification ☐ Medication Recommendation	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Urgent Access Nurse Practitioner **(NH ED physician only)**	☐ Assessment ☐ Diagnostic Clarification ☐ Medication Recommendation	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ RAAM – Rapid Access to Addiction Medicine	☐ Alcohol ☐ Opiates ☐ Other:	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Seniors Mental Health Contact Person for Appointment: _____ Relationship: _____ Phone Number: _____ INCLUDE ALL RECENT LAB WORK, CT/MRI HEAD, BMD, RELEVANT CONSULTATIONS	☐ Cognitive Decline ☐ New Mental Health ☐ Longstanding Mental Health	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ WRICCP - Wellness Recovery Integrated Comprehensive Care Program	**Must meet the following criteria:** ☐ Recent suicide attempt ☐ Recent / frequent ER/Admission Inpatient ☐ Acute phase of mental health illness ☐ Significant impact to functioning	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Adult Group Therapy (check one) ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Emotion Dysregulation ☐Schizophrenia ☐ ADHD ☐ Pain Control and Wellness		Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Day Hospital (3 days per week)	☐ Complex mental health ☐ Impairments with daily functioning	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ GEM- Guiding Emotions Mindfully (1.5 days per week)	☐ Severe emotion dysregulation ☐ History of trauma	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ Medication Clinic – to complete this referral you must also go to page 3 to input additional required information		Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A

☐ ECT – Electroconvulsive Therapy – to complete this referral you must also go to Page 4 to input additional required information	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ rTMS – Repetitive Transcranial Magnetic Stimulation– to complete this referral you must also go to Page 5 to input additional required information	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A
☐ CTO – Community Treatment Order Assess suitability: ☐ 30+ days inpatient mental health admission within past 3 years ☐ 2 lengthy inpatient mental health admissions within past 3 years ☐ previous CTO in the past	Intake Date: _____ Completed: _____ See Notes: ☐Yes ☐N/A

SECTION C: PRESENTING SYMPTOMS:

Current challenges/concerns: ☐ attached document ☐ see Meditech note dated _____

_____

_____

Previous/Current Mental Health Diagnosis (mild/moderate/severe as per PHQ-9): ☐ attached document ☐ see Meditech note dated _____ _____

_____

Previous/Current Medical Diagnosis: ☐ attached document ☐ see Meditech note dated _____

_____

_____

Previous / Current Medication(s) / dosages: ☐ attached document ☐ see Meditech note dated _____

_____

_____

Allergies: _____

SECTION D: RISK

Please complete the following chart:

Problem	Present (within past 6 months)		Past (6 months or more)		Denied	Unknown
	Yes	No	Yes	No		
Alcohol/Substance Use						
Violent behaviour						
Suicidal ideation						
Suicidal attempts						
Self-harming behaviour						

If answered yes above, please identify/report concerns: _____

_____

Referring Source (print): _____ M.D./N.P. Billing #: _____

Referring Source Phone: _____ Referring Source Fax: _____

Signature: _____ Referral Date: _____

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Over-The-Counter Products

	May Bring	Do Not Bring
For Pain	Acetaminophen (Tylenol), Ibuprofen (Advil) are acceptable in an unopened original bottle/container.	Combination meds such as "Cold and Sinus" or "Night time". Anything containing Benadryl or Pseudoephedrine.
For Sleep	Melatonin – an unopened original bottle/container.	"Sleep Eze" or "Nyquil". Anything containing Benadryl
NRT	Remember to bring smoking cessation materials such as patches, gum, lozenges, inhalers, sprays or prescribed medication such as Champix or Zyban	Vape, e-cigarettes, cannabis, tobacco
For Allergies	Seasonal allergies, Claritin, Aerius or Reactin.	Sudafed or Benadryl
Heartburn/ Stomach issues	Ranitidine (Zantac), Pepto bismol, Tums – unopened original bottle/container.	Gravol (dimenhydrinate), Imodium or Lomotil.
Vitamins/ Supplements	Vitamins – must be an unopened original bottle/container. Ensure or Boost.	*Protein powder and supplements require Nurse Practitioner's approval.*

Clients on prescribed medications must bring an 18 day supply of medications that your health care provider has prescribed and packaged in blister packs.

Please also bring any prescribed medications that cannot be packaged in a blister pack (i.e. creams, certain medication for diabetes, injectable(s)).

Any questions, please feel free to call and ask the Nurse Practitioner at 905-378-4647 ext. 32516.

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