



niagarahealth

Extraordinary Caring. Every Person. Every Time.

## New Port Centre

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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](mailto:NewPortAdmin@niagarahealth.on.ca) • Web: [www.niagarahealth.on.ca/site/mental-health-addictions](http://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 (CAPS Form) and fax it to the New Port Centre along with the medical profile.

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.\*

Revised: NOVEMBER 2017



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Affix Client Label

**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?

	Yes <input type="checkbox"/>	Year _____	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Comments
Tetanus	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis A Series	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B Series	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	Yes <input type="checkbox"/>	Year _____	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Comments/Results
Hepatitis B	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis C	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Provider Signature</b>	<b>Office Stamp</b>
<b>Print Name</b>	
<b>Client/Patient Signature</b>	
<b>Date:</b> (dd/mm/yyyy)	

## Centralized Access to Psychiatric Services (CAPS) Referral Form

St. Catharines Site     Niagara Falls Site     Welland Site  
Telephone: 905-378-4647 Ext. 49463    NEW Fax: 289-398-1067

Centralized Access to Psychiatric Services (CAPS) is the access point for adult psychiatry within the Niagara Health Mental Health and Addiction Program. The CAPS intake process will ensure that referrals are directed to appropriate psychiatric services based on client needs.

Referred By: \_\_\_\_\_ Physician's Billing Number: \_\_\_\_\_

Date of Referral: \_\_\_\_\_ (dd/mm/yyyy)

Name: \_\_\_\_\_ Health Card Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Cell Phone Number: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (dd/mm/yyyy) Age: \_\_\_\_\_ Gender:  Male  Female

Family Physician: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Telephone Number: ( ) \_\_\_\_\_

Client Informed of Referral?  Yes  No

Psychiatric/Medical Diagnosis: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**Intervention Requested:**

- Assessment                                     Treatment Recommendations                                     Diagnostic Clarification  
 Other: \_\_\_\_\_

**This portion to be filled out and signed by referring physician or other health care worker**

- |  |  |                                       |  |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Threat to self    | <input type="checkbox"/> In past 30 days | <input type="checkbox"/> In past year | <input type="checkbox"/> None previous |
| <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> In past 30 days | <input type="checkbox"/> In past year | <input type="checkbox"/> None previous |
| <input type="checkbox"/> Risk of violence  | <input type="checkbox"/> In past 30 days | <input type="checkbox"/> In past year | <input type="checkbox"/> None previous |

**If risk of violence identified, check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Verbally or physically threatening                       | <input type="checkbox"/> Know to actively use illicit substances or excessive alcohol    |
| <input type="checkbox"/> Attacking with objects                                   | <input type="checkbox"/> Current Police involvement/criminal charges/probation/parole    |
| <input type="checkbox"/> Disruptive - easily angered, shouts, confused, irritable | <input type="checkbox"/> Past criminal charge involving violence                         |
| <input type="checkbox"/> Known to carry a weapon                                  | <input type="checkbox"/> History of code white/aggressive behaviour in clinical scenario |

**List of Current Medications: Please Print Clearly**

Name of Medication	Route	Dose	Frequency

Allergies: \_\_\_\_\_

Signature / Status \_\_\_\_\_

Date (dd/mm/yyyy) \_\_\_\_\_



REF18