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 (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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Client Name: _____
DOB: _____ (mm/dd/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: NOVEMBER 2017

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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

☐ Threat to self	☐ In past 30 days	☐ In past year	☐ None previous
☐ Attempted suicide	☐ In past 30 days	☐ In past year	☐ None previous
☐ Risk of violence	☐ In past 30 days	☐ In past year	☐ None previous

If risk of violence identified, check all that apply:

☐ Verbally or physically threatening
☐ Attacking with objects
☐ Disruptive – easily angered, shouts, confused, irritable
☐ Known to carry a weapon
☐ Know to actively use illicit substances or excessive alcohol
☐ Current Police involvement/criminal charges/probation/parole
☐ Past criminal charge involving violence
☐ 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

Chart Copy – Do Not Destroy

Rev. 08/2016 (v2)