NEW YORK STATE OF OPPORTUNITY. | Justice Center for the Protection of People with Special Needs

Form Checklist for Major Medical Treatment Decisions

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

To avoid delays in case processing, all SDMC forms must be completed and all required supporting documents submitted together.

- Do not double side case information, including forms
- Do not staple pages together

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Be sure to include fully completed:

- ☐ **SDMC Form 200** Declaration for Major Medical Treatment
- ☐ **SDMC Form 210** Certification on Capacity for Major Medical Treatment
- ☐ **SDMC Form 220-A** Certification on Need for Major Medical Treatment
- ☐ **SDMC Form 220-B** Supplemental Medical Information for Major Medical Treatment

Other required documents related to the procedure:

- ☐ Annual Physical Exam (Most recent annual physical)
- ☐ Most current lab work
- ☐ Most current EKG (If available)
- ☐ Most current chest x-ray (If available)
- ☐ Physician's consult, office notes, scripts, etc.
- ☐ Any other diagnostic testing or related procedures

Please contact SDMC with any questions at (518) 549-0328.

NEW YORK STATE OF OPPORTUNITY. | Justice Center for the Protection of People with Special Needs

Declaration for Major Medical Treatment

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: sdmc@justicecenter.ny.gov

INSTRUCTIONS:

All Parts of this form must be completed. Type or print in black ink.

Part 16 – Declarant must sign and date where indicated.

Please avoid the use of abbreviations

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Part 1. Patient Information

Last Name:		First Name:	
Date of Birth:	Age:	Religion:	Sex: ☐ MALE ☐ FEMALE
Street Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
County of Residence:			

Type of Residence

☐ Intermediate Care Facility ☐ Family Care ☐ Hospital Psychiatric Ward ☐ Nursing Home ☐ Assisted Living

☐ Community Residence ☐ Individualized Residential Alternative (IRA) ☐ OMH funded or approved housing ☐ Adult Home ☐ Waiver

☐ Developmental Center ☐ Psychiatric Center ☐ Other Services: _____

Part 2. Proposed Major Medical Treatment(s)

Briefly describe the proposed treatment being sought on behalf of the patient.
See Part 4 on the Certification on Need for Major Medical Treatment (SDMC Form 220-A).

Part 3. Biopsy

Will a biopsy be performed? If yes, please indicate type. ☐ **YES** **Type:** _____ ☐ **NO** ☐ **UNKNOWN**

Part 4. Anesthesia

Is the use of general anesthesia anticipated?
The response must match Part 8 on the Certification on Need for Major Medical Treatment (SDMC Form 220-A). ☐ **YES** ☐ **NO**

Part 5. Second Opinion

Has a second opinion been obtained? If yes, please attach. ☐ **CAPACITY** ☐ **BEST INTEREST** ☐ **NO**

Patient Last Name:

For SDMC Use Only:

Part 6a. Declarant The declarant should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interest for this specific case.			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Part 6b. Alternate Declarant The alternate declarant will be contacted if the declarant is not available and should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interests for this specific case.			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Part 7. Other Service Providers Provide information relating to other service providers that are involved in the care of this patient			
Part 7a. Nurse			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Patient Last Name:

For SDMC Use Only:

Part 7b. Residential Manager or Director | Family Care Liaison			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Part 7c. Service Coordinator | Social Worker			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Part 7d. Hospice Contact			
Last Name:		First Name:	
Title:		Business Email Address:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Part 7e. Hospital | Nursing Home Contact Provide the following information if the patient has been transferred to a hospital, rehabilitation center or nursing home			
Last Name:		First Name:	
Title:		Business Email Address:	
Hospital | Nursing Home Name:			
Business Address:			

Patient Last Name:

For SDMC Use Only:

City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Pager: (Include area code)		Patient's Room Number:	

Part 8. What agency operates the Day Program?

(Please avoid abbreviations)

Part 9. Other Agencies

Agency Name(s):
List any other agencies providing services not previously mentioned.

Part 10a. Legally Authorized Surrogates
Provide the following information for known surrogates.

Status of the patient's mother: ☐ Living (list below) ☐ Deceased ☐ Whereabouts Unknown

Status of the patient's father: ☐ Living (list below) ☐ Deceased ☐ Whereabouts Unknown

Check all that apply and list in the box below:

☐ Parent ☐ Spouse ☐ Adult Child

☐ Health Care Proxy ☐ Guardian

For current or former OPWDD patients ONLY:
Are there any actively involved adult family members that have a significant and on-going relationship with the patient sufficient enough to know the care needs of the patient? ☐ **YES** list in the box below ☐ **NO**

For OMH patients ONLY:
Is there a legally authorized surrogate? This includes a parent, spouse or adult child of the patient. ☐ **YES** list in the box below ☐ **NO**

For any surrogate listed below, please explain why they do not wish to provide informed consent:

Last Name:	First Name:
Email Address:	Relationship:
Address:	

Patient Last Name:

For SDMC Use Only:

City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the above referenced surrogate has an opinion on the proposed treatment.

☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Part 10b. Legally Authorized Surrogates
Provide the information for any additional surrogates.

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the above referenced surrogate has an opinion on the proposed treatment.

☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Part 10c. Legally Authorized Surrogates
Provide the information for any additional surrogates.

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Patient Last Name:

For SDMC Use Only:

Indicate if the above referenced surrogate has an opinion on the proposed treatment.

☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Part 11a. Correspondents, Community Advocates or Family Care Provider(s)

☐ **N/A** proceed to Part 12

Correspondent means a person who has demonstrated a genuine interest in promoting the best interests of the patient by having a personal relationship with the patient, by participating in the patient's care and treatment, by regularly visiting the patient, or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)].

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the correspondent has an opinion on the proposed treatment.

☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Other: _____

Part 11b. Correspondents, Community Advocates or Family Care Provider(s)

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the correspondent has an opinion on the proposed treatment

☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Other: _____

Patient Last Name:

For SDMC Use Only:

Part 12a. Supporting Documentation	
As the Declarant, I have read the Certification on Capacity for Major Medical Treatment (SDMC Form 210) that has been completed by a NYS Licensed Psychiatrist or NYS Licensed Psychologist.	☐ Yes
Part 12b. Supporting Documentation	
As the Declarant, I have read the Certification on Need for Major Medical Treatment (SDMC Form 220-A) that has been completed by a Physician | Dentist | Podiatrist.	☐ Yes
Part 13. Additional Information	
List the title of the person who explained the proposed major medical treatment(s) to the patient.	
Describe the patient's reaction when the treatment(s) was/were explained, and any opinions expressed.	
Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent for this procedure.	
Based on your personal knowledge of this patient, explain in your own words why you believe the proposed treatment(s) is/are in the best interest of the patient.	

Patient Last Name:

For SDMC Use Only:

Part 14. Communication Needs

Does the patient understand English? ☐ **YES** ☐ **NO**

Does the patient speak English? ☐ **YES** ☐ **NO**

If the patient is a non-English speaker, please indicate the language they speak or understand: _____

Does the patient require an interpreter? ☐ **YES** ☐ **NO**

If YES, please indicate type (foreign language, sign language, other):

Does the patient use a communication board or other assistive device? ☐ **YES** ☐ **NO**

If YES, please indicate type of assistive device:
Please ensure that such device is brought to the hearing.

Is the patient able to verbally communicate their needs? ☐ **YES** ☐ **NO**

Is the patient able to demonstrate an understanding of verbal communications? ☐ **YES** ☐ **NO**

How do they communicate their needs?

Part 15. Hearing

MHL Article 80 requires the patient to be present at the hearing.
Is there a medical condition that would prevent the patient from attending the hearing? ☐ **YES** ☐ **NO**
If Yes, please explain.

Part 16. Attestation

The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Declarant: Date: ___/___/___

MM DD YEAR

NOTE:
This form must be dated the same or later than the other forms in this case. This includes the:

- Certification on Capacity for Major Medical Treatment (SDMC Form 210);
- Certification on Need for Major Medical Treatment (SDMC Form 220-A);
- Supplemental Medical Information for Major Medical Treatment (SDMC Form 220-B).