



INSTRUCTIONS:

All Parts of this form must be completed. Please return to the provider agency so a completed packet can be submitted to SDMC.

Type or print in black ink.

Part 10 – Attending Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

YES NO

This is defined as the proposed treatment is of an urgent need that is expected to be performed within 10 days.

If YES, you must state the medical facts to support the request.

Part 2. Patient Information

Last Name:

First Name:

Agency where the Patient Resides or Receives Services:

(Please avoid abbreviations)

Phone:

Include area code ()

Ext:

Fax:

Include area code ()

Part 3. Physician/Dentist/Podiatrist

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:

Include area code ()

Ext:

Fax:

Include area code ()

Cell:

Include area code ()

Part 4. Findings

Date of Review or Examination of Patient:

Date:

MM DD YEAR

I request informed consent for the following medical treatment(s):

Patient Last Name:

For SDMC Use Only:

Part 5. Biopsy

Do you anticipate performing a biopsy? YES Type: _____ NO UNKNOWN
If yes, please indicate type.

Part 6. Request

a. Clinical indications for the requested proposed major medical treatment(s):

b. The following diagnostic tests/examinations have been performed to confirm my recommendation(s). Please include copies of reports.

c. In my clinical opinion, the risks specific to this proposed major medical treatment(s) is/are:

d. In my clinical opinion, the benefits specific to this proposed major medical treatment(s) is/are:

Part 7. Anesthesia

Is the use of general anesthesia anticipated? YES NO
(Only answer YES if the patient will be unconscious and intubated during the treatment.)
When the treatment plan does not include general anesthesia, if on the day of the proposed major medical treatment(s) the use of general anesthesia becomes necessary, Public Health Law Section 2805-d provides for the disclosure of reasonably foreseeable risks. Common/severe complications of general anesthesia include: hoarseness, nausea, sore throat, broken teeth, tracheal or esophageal injuries, respiratory distress, cardiac failure and death. (Source: American Society of Anesthesiologists)

Part 8. Alternatives

Is there an alternate procedure that is less invasive available to this patient? YES NO
If YES, please state the procedure.

Patient Last Name:

For SDMC Use Only:

Please explain the rejection of this alternative procedure.

Part 9. Risks

What are the risks of non-treatment?

Part 10. Attestation

The above information and statements are given to the best of my knowledge, complete and truthful.

Signature of Physician/Dentist/Podiatrist:

Date:

____ / ____ / ____
MM DD YEAR

Part 11. Co-signer Attestation

If the evaluation has been performed by OTHER than a licensed physician, dentist or podiatrist, this form must be CO-SIGNED below.

Print

Last Name:

Print

First Name:

Check all that apply:

Licensed Physician Licensed Dentist Licensed Podiatrist

Professional License Number:

I concur with the above clinical evaluation. The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Licensed Physician/Dentist/Podiatrist:

Date:

____ / ____ / ____
MM DD YEAR