



Form Checklist for End of Life Care 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 300 Declaration for End of Life Care
SDMC Form 310 Certification on Capacity for End of Life Care
SDMC Form 320A-B Attending Physician and Concurring Physician Certification for End of Life Care
SDMC Form 330 Supplemental Medical Information for End of Life Care

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

Reminder: The MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed before an SDMC End of Life decision granting consent can take effect.

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



Justice Center for the Protection of People with Special Needs

Declaration for End of Life Care

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 14 – 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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
----------------	------	-----------	--

Street Address:

City:	State:	Zip:
-------	--------	------

Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>
---	------	---	--

County of Residence:

Type of Residence

Intermediate Care Facility
 Family Care
 Individualized Residential Alternative (IRA)
 Nursing Home
 Community Residence
 Developmental Center
 Assisted Living
 Adult Home
 Waiver
 Other Services: _____

Part 2a. 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: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>
---	------	---	--

Patient Last Name:

For SDMC Use Only:

Part 2b. 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: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>

Part 3. Other Service Providers

Provide information relating to other service providers that are involved in the care of this patient

Part 3a. Nurse

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>

Part 3b. Residential Manager or Director | Family Care Liaison

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>

Patient Last Name:

For SDMC Use Only:

Part 3c. Service Coordinator | Social Worker

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>

Part 3d. Hospice Contact

Last Name:		First Name:	
Title:		Business Email Address:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>

Part 3e. 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:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>
Pager: <small>(Include area code)</small>		Patient's Room Number:	

Part 4. What agency operates the Day Program?

(Please avoid abbreviations)

Patient Last Name:

For SDMC Use Only:

--

Part 5. Other Agencies
Agency Name(s): List any other agencies providing services not previously mentioned.

Part 6a. Legally Authorized Surrogates Provide the following information for known surrogates.
Status of the patient's mother: <input type="checkbox"/> Living (List below) <input type="checkbox"/> Deceased <input type="checkbox"/> Whereabouts Unknown
Status of the patient's father: <input type="checkbox"/> Living (List below) <input type="checkbox"/> Deceased <input type="checkbox"/> Whereabouts Unknown
Check all that apply and list in the box below: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Adult Child <input type="checkbox"/> Health Care Proxy <input type="checkbox"/> Guardian

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?	<input type="checkbox"/> YES list in the box below	<input type="checkbox"/> NO proceed to Part 8
--	--	---

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

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 or withdrawal of treatment.
<input type="checkbox"/> Does not wish to make decision <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion

How contacted?
<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person
<input type="checkbox"/> Unable to contact <input type="checkbox"/> Other: _____

Patient Last Name:

For SDMC Use Only:

Part 6b. 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 or withdrawal of treatment.

Does not wish to make decision Agree Disagree No Opinion

How contacted?

Phone Mail Email In Person

Unable to contact Other: _____

Part 6c. 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 or withdrawal of treatment.

Does not wish to make decision Agree Disagree No Opinion

How contacted?

Phone Mail Email In Person

Unable to contact Other: _____

Patient Last Name:

For SDMC Use Only:

Part 7a. Correspondents, Community Advocates or Family Care Provider(s) N/A proceed to Part 8
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: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>
Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment. <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion			
How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact <input type="checkbox"/> Other: _____			

Part 7b. Correspondents, Community Advocates or Family Care Provider(s)

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Fax: <small>Include area code ()</small>	Cell: <small>Include area code ()</small>
Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion			
How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Other: _____			

Patient Last Name:

For SDMC Use Only:

--

Part 8. Visit
If the patient cannot attend the hearing, he or she will be visited by at least one panel member. Hospitalized patients are visited. Please explain the medical condition that would prevent the patient from attending the hearing:

Part 9. Supporting Documentation	
As the Declarant, I have read the Certification on Capacity for End of Life Care (SDMC Form 310) stating that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Consulting Physician or NYS Licensed Psychologist.	<input type="checkbox"/> YES <input type="checkbox"/> YES
As the Declarant, I have read the Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B) describing the patient's medical condition, the risks, benefits and alternative(s) to the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Concurring Physician.	<input type="checkbox"/> YES

Part 10a. Proposed Withholding
The proposed withholding of life sustaining treatment(s) is/are as follows: See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B).

Part 10b. Proposed Withdrawal
The proposed withdrawal of life sustaining treatment(s) is/are as follows: See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B).

Part 10c. Artificial Nutrition and/or Hydration
Has the physician requested to withhold / withdraw life-sustaining artificially provided nutrition or hydration for the patient? <input type="checkbox"/> YES <input type="checkbox"/> NO

Patient Last Name:

For SDMC Use Only:

Part 11. Hospice		
Is a Hospice admission anticipated? If the patient has been evaluated by Hospice, please attach the evaluation.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Part 12. Additional Information		
List the title of the person who explained the proposed treatment decision to the patient.		
Describe the efforts to determine the moral and religious beliefs of the patient, and the patient's reaction when the proposed withholding/withdrawal of life sustaining treatment(s) was/were explained.		
Based on your <u>personal knowledge</u> of this patient, explain in <u>your own words</u> why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment.		
Based on your <u>personal knowledge</u> of this patient, explain in <u>your own words</u> why you believe the proposed treatment decision(s) is/are in the best interest of the patient.		

Patient Last Name:

For SDMC Use Only:

Part 13. Communication Needs	
Does the patient understand English?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient speak English?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If the patient is a non-English speaker, please indicate the language they speak or understand: _____	
Does the patient require an interpreter?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please indicate type (foreign language, sign language, other): _____	
Does the patient use a communication board or other assistive device?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the patient able to demonstrate an understanding of verbal communications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How do they communicate their needs? _____	

Part 14. Attestation	
This request is based on the patient’s qualifying medical condition other than intellectual or developmental disability, with recognition that a person with an intellectual or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without intellectual or developmental disabilities and without any financial considerations that affect the health care provider or any other party.	
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 End of Life Care (SDMC Form 310);
- Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B);
- Supplemental Medical Information for End of Life Care (SDMC Form 330).

REMINDER:
 The MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed before an SDMC End of Life decision granting consent can take effect.