



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:

Empty box 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.



**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: <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			
<input type="checkbox"/> Intermediate Care Facility	<input type="checkbox"/> Family Care	<input type="checkbox"/> Hospital Psychiatric Ward	<input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living
<input type="checkbox"/> Community Residence	<input type="checkbox"/> Individualized Residential Alternative (IRA)	<input type="checkbox"/> OMH funded or approved housing	<input type="checkbox"/> Adult Home <input type="checkbox"/> Waiver
<input type="checkbox"/> Developmental Center	<input type="checkbox"/> Psychiatric Center	<input type="checkbox"/> 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? YES Type: _____ NO UNKNOWN
If yes, please indicate type.

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: <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 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: <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 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: <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 7b. 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>

Part 7c. 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 7d. 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 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.			
<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: _____		

Part 11a. Correspondents, Community Advocates or Family Care Provider(s)	<input type="checkbox"/> 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: <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.			
<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:	_____		

Part 11b. 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			
<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 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.	<input type="checkbox"/> Yes
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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.	<input type="checkbox"/> Yes
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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:

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Part 14. 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 15. Hearing	
MHL Article 80 requires the patient to be present at the hearing.	
Is there a <u>medical condition</u> that would prevent the patient from attending the hearing?	<input type="checkbox"/> YES <input type="checkbox"/> 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: <i>Mary McCah</i>	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).