



Justice Center for the Protection of People with Special Needs

Attending Physician and Concurring Physician Certification for End of Life Care

401 State Street
Schenectady, NY 12305
Questions: 518-549-0328

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 AND Concurring Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

The withholding or withdrawing of life sustaining treatment is requested within 10 days.

YES

NO

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 3a. Attending Physician

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:

Include area code ()

Ext:

Cell:

Include area code ()

Fax:

Include area code ()

Part 3b. Concurring Physician

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:

Include area code ()

Ext:

Cell:

Include area code ()

Fax:

Include area code ()

Patient Last Name:

For SDMC Use Only:

Part 4. Attending and Concurring Physician Findings

As a result of my examination, I have determined, to a reasonable degree of medical certainty, that the patient has been diagnosed with the following medical conditions:

Check all that apply; at least one box must be checked:

A terminal condition where the patient has an illness or injury from which there is no recovery and which reasonably can be expected to cause death within one year. Briefly describe

_____ ; or

Permanent unconsciousness; or

A medical condition, other than intellectual or developmental disability which requires life-sustaining treatment, is irreversible, and which will continue indefinitely. Briefly describe

Signature of Attending Physician:

Casey Shepherd, MD

Date:

____ / ____ / ____
MM DD YEAR

Date of Review or Examination of Patient:

____ / ____ / ____
MM DD YEAR

Signature of Concurring Physician:

Amelia Jones, MD

Date:

____ / ____ / ____
MM DD YEAR

Date of Review or Examination of Patient:

____ / ____ / ____
MM DD YEAR

Patient Last Name:

For SDMC Use Only:

Part 5. Attending and Concurring Physician Request to Withhold/Withdraw LST

Instructions:

Parts 5a-e Completed by the Attending Physician and reviewed by Concurring Physician.

The Concurring Physician may note additional comments regarding the life sustaining treatment and/or the burden of treatment for this patient.

- a. **Based on the patient's medical diagnosis, I request consent to WITHHOLD the following life-sustaining treatment(s).** Please provide the exact wording that should be written on the SDMC consent form.
(To WITHHOLD treatment means to not initiate or provide treatment.)

MUST CHECK YES OR NO

DNR Order: Do not attempt Resuscitation

YES NO

DNI: Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs.

YES NO

Withhold future hospitalizations unless pain or severe symptoms cannot otherwise be controlled

YES NO

Withhold Antibiotics

YES NO

Withhold Vasopressors to support blood pressure

YES NO

Withhold IV Fluids

YES NO

Please list any additional life-sustaining treatment that should be withheld:

Based on the patient's medical diagnosis, I request consent to WITHDRAW the following life-sustaining treatment(s). Please provide the exact wording that should be written on the SDMC consent form.

(To WITHDRAW treatment means to stop or remove treatment.)

MUST CHECK YES OR NO

Withdraw Mechanical Ventilation

YES NO

Withdraw Antibiotics

YES NO

Withdraw Vasopressors to support blood pressure

YES NO

Withdraw IV Fluids

YES NO

Please list any additional life-sustaining treatment that should be withdrawn:

Patient Last Name:

For SDMC Use Only:

b. I find that the life-sustaining treatment(s) listed above would impose an EXTRAORDINARY BURDEN on the patient in light of the patient's medical condition.

(Please describe the EXTRAORDINARY BURDEN the above life-sustaining treatments pose to the patient. If available, list any test or supporting information that confirm your findings. Include copies of medical records, progress notes, consultations or other relevant reports.)

c. Is this a request to WITHHOLD or WITHDRAW life-sustaining artificially provided nutrition or hydration for the patient?

YES

NO

If YES, I find to a reasonable degree of medical certainty that:

There is no hope of maintaining life; or

The artificially provided nutrition or hydration would impose an extraordinary burden on the patient.

d. If reasons to withhold and/or withdraw life sustaining artificially provided nutrition differ from 5b above, describe the EXTRAORDINARY BURDEN of providing artificial hydration or nutrition to the patient, and any diagnostic testing/examinations that confirm this recommendation. Include copies of reports.

e. Do you anticipate a Hospice admission?

If YES, include the hospice evaluation with the submission of this form, if available.

YES

NO

Patient Last Name:

For SDMC Use Only:

Part 6. Expected Outcome

Describe the expected outcome of providing or continuing life-sustaining treatment(s) to the patient and, if available, list any tests or information that confirms these findings. Include copies of medical records, progress notes, consults or other relevant reports.

Part 7. Alternatives

Is there an alternate procedure available to this patient that will preserve, improve or restore the patient's health?

YES

NO

If YES, please state the procedure:

Please explain the rejection of this alternate procedure:

Patient Last Name:

For SDMC Use Only:

Part 8. Justification by Attending Physician
In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

Part 9. Justification by Concurring Physician
In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

Part 10. Attestation (Attending Physician and Concurring Physician must sign and date the attestation)		
The above information and statements are given to the best of my knowledge, complete and truthful.		
Signature of Attending Physician: <i>Casey Shepherd, MD</i>	Date:	____ / ____ / ____ MM DD YEAR
Signature of Concurring Physician: <i>Amelia Jones, MD</i>	Date:	____ / ____ / ____ MM DD YEAR