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

Supplemental Medical Information for End of Life Care

SDMC
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 8 – The person submitting the form must complete, sign and date where indicated.

Please attach: consults, progress notes, annual physical exam, results of diagnostic tests and other related documentation.

For SDMC Use Only:

Part 1. Patient Information

Last Name: Chase | First Name: Michael

Part 2. Current Medications

a. Provide information pertaining to the patient's current medications.

Current medication	Dosage	Frequency	Mode of Intake
Digoxin	0.25 mg/day		IV
Depakote	500 mg/day		
Dopamine	16 mcg./kg/day		IV
Mannitol	0.25 g/kg/day		IV
Please see attached			

b. List any drugs requiring frequent blood level monitoring. Include a copy of the most recent lab work.

Depakote

Part 3. Allergies

Any known allergies?

Penicillin, bananas

Patient Last Name: Chase

For SDMC Use Only:

Part 4. Exams and Tests	
a. Date of most recent annual physical examination. Include a copy of the most recent physical. **Date:** 05/24/2017	
b. List any abnormal findings from exams and tests: Edema in lower legs	☐ **N/A**
c. Date of most recent EKG. Include a copy. **Date:** 07/24/2017	☐ **N/A**
d. Date of most recent chest x-ray. Include a copy. **Date:** 07/24/2017	☐ **N/A**
e. Date of most recent laboratory tests. Include a copy of the most recent lab work. **Date:** 07/24/2017	
Part 5. Additional Information	
a. List any cardiac or pulmonary condition(s): Congestive heart failure	☐ **N/A**
b. List any major illness, surgery, and/or hospitalizations in the last year: GI Bleed (11/16); Aspiration pneumonia 02/17, 4/17 & 6/17	☐ **N/A**
c. List any other known physical condition or medical diagnosis: GERD, pneumonia, HTN, seizure disorder	
Part 6. Prior SDMC Review	
Has the patient been reviewed by SDMC previously?	☑ Yes ☐ No ☐ Unknown

Patient Last Name: Chase

For SDMC Use Only:

Part 7. Form Submitter's Contact Information			
Last Name: Moore		First Name: Bessie	
Business Email Address: Bessie.moore@opwdd.ny.gov		Title: RN, CMHN	
Agency Name: (Please avoid abbreviations) Sunmount DDSO			
Business Address: 42 Keystone Lane			
City: Adirondack		State: NY	Zip: 14321
Phone: Include area code (518) 548-2154	Ext: 215	Fax: Include area code (518) 204-8792	Cell: Include area code (518) 514-7524

Part 8. Attestation

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

Signature of Form Submitter: *Bessie Moore RN*

Date: 07 / 24 / 2017

MM DD YEAR

PLEASE REMEMBER TO ATTACH

Documentation related to the requested End of Life Care:

- Consults
- Progress notes
- Annual Physical Exam
- Results of diagnostic tests

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.