

Mail all five completed forms and supplemental information to:

NYS Justice Center for the Protection
of People with Special Needs
SDMC
401 State Street
Schenectady, NY 12305

SDMC FORM 320-B

Concurring Physician
Certification



Do not double side case information, including forms. Do not staple pages together.

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF
LIFE SUSTAINING TREATMENT ON BEHALF OF

CONCURRING PHYSICIAN
CERTIFICATION

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

- 1a. Is an Expedited Review necessary? ____ Yes ____ No
- 1b. If an expedited case review is being requested, state the medical facts indicating its need. An expedited case review is where the patient's needs are urgent but not an emergency.

2. I, _____, am an attending physician for the patient and my
(Print Name)
professional license number is _____.

3. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

4. On _____ I **personally** examined _____.
(Date) (Patient's Name)

As a result of such examination, I have determined to a reasonable degree of medical certainty that the patient lacks capacity and has been diagnosed with the following medical condition/s (**must check one or all that apply**):

- a terminal condition in that 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; or,
- permanent unconsciousness; or
- a medical condition **other than mental retardation or developmental disability** which requires life-sustaining treatment, is irreversible and which will continue indefinitely.

5a. Based on the medical diagnosis, I request consent to **WITHHOLD** the following life-sustaining treatment(s) (**write exact wording you want on the consent form**):

Based on the medical diagnosis, I request consent to **WITHDRAW** the following life-sustaining treatment(s) (**write exact wording you want on the consent form**):

I find further that the life-sustaining treatment would impose an extraordinary burden on the patient **in light of the person's medical condition** other than the person's mental retardation or developmental disability.

5b. What is **the extraordinary burden of the life sustaining treatment(s)** for the patient? If available, list any tests or supporting information that confirm your findings (Include copies of reports):

5c. Is this a request to withhold or withdraw life-sustaining artificially provided nutrition or hydration for the patient? ____ Yes ____ No (*If no, proceed to Question 8.*)

5d. If yes, I find to a reasonable degree of medical certainty that:

- there is no reasonable hope of maintaining life; or
- the artificially provided nutrition or hydration impose an extraordinary burden on the patient.

5e. If not the same as 5b above, describe the extraordinary burden of providing artificial nutrition and hydration and, if available, any diagnostic tests/examinations that have been performed to confirm my recommendations(s). (Include copies of reports.).

5f. Do you anticipate hospice admission? ____ Yes ____ No

6. Describe the expected outcome of providing or continuing life-sustaining treatment(s) to the patient and, if available, list any tests or supportive information that confirms your findings (include copies of reports.): _____

7. In my clinical opinion the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

8a. Is there an alternative procedure available to this patient that will preserve, improve, or restore the person's health? ____ Yes ____ No

8b. If yes, please state procedure: _____

8c. Please explain your rejection of this optional choice.

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

Print Name Clearly

Signature

Date

Please check to see that you have answered all questions.