

Mail all **four completed** forms and **supplemental information** to:

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

**INSTRUCTIONS FOR
SDMC FORM 220-A**

**Certification on Need
for Major
Medical Treatment**



If this is your first time preparing a case or you have questions, call 518-549-0328.

Verify the answer includes. . . .

- 1a. . . . Yes or No is checked (see 1b for definition of Expedited Review).
- 1b. . . . The medical facts supporting the need for a more urgent (but not an emergency) treatment. This means that in the medical opinion of the physician/dentist/podiatrist the patient needs to have the procedure in the next week to 10 days. If you are aware that this is not the case, please contact the physician and change the answers in 1a and 1b if the doctor agrees, before sending the case to SDMC.
2. . . . The full name, title of the person completing the examination and license number.
3. . . . The complete mailing address and work phone and fax numbers of the person completing the examination.
- 4a. . . . The date the patient was examined or the medical record reviewed, the patient's name and list each of the proposed major medical treatments being requested.
- 4b. . . . Yes or No is checked and the type should be noted i.e.: needle, excisional, etc.
5. . . . Yes or No is checked. Included on the form are the risks/benefits of HIV testing.
6. . . . Yes or No is checked. For the purposes of SDMC, answer yes only if the patient will be unconscious and intubated during the procedure. *Intravenous (IV) sedation and Monitored Anesthesia Care (MAC) are not considered general anesthesia*. Included on the form is a list of common and most severe risks associated with the use of general anesthesia.
- 7a. . . . The clinical justification (i.e.: symptoms, history, presentation, etc.) for the procedure(s).
- 7b. . . . The specific risks associated with the requested procedure(s).
- 7c. . . . The specific benefits associated with the requested procedure(s).
8. . . . Diagnostic tests or examinations that have already been performed that confirmed the diagnosis/indication(s) for the requested procedure(s). Include copies of the results in the case.

9. . . . Yes or No is checked. If yes, the procedure is listed and an explanation of the reason for rejection is included.
10. . . . The risks to the patient of not doing the requested treatment/procedure(s).
11. . . . The full name of person completing this form, their signature and date.
12. . . . If the examination was done by anyone other than a licensed physician/dentist/podiatrist (ie.: NP, PA, etc.), a licensed physician/dentist/podiatrist must CO-SIGN the form and their title must be listed. **They must print their name clearly**, sign and date the form and provide their license number.