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

Certification on Capacity for Major Medical Treatment

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 3 & 4 – A NYS Licensed Psychologist or Psychiatrist must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. 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 2. Clinician

Last Name:	First Name:		
Email Address:	Professional License Number:		
Business Address:			
City:	State:	Zip:	
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Check all that apply: ☐ Licensed Psychiatrist ☐ Licensed Psychologist	Date of Examination of Patient | Review of Record:		

a. As a result of this examination/review, the patient has been diagnosed with the following intellectual disability or psychiatric diagnosis:

b. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.)

Patient Last Name:

For SDMC Use Only:

c. Summarize the clinical evaluation, including the patient's reaction, when you explained the proposed major medical treatment(s) and its risks and benefits that validate your opinion regarding the patient's decision making ability.

Part 3. Attestation

It is my clinical opinion that the patient **DOES NOT** have the capacity to make an informed decision regarding this major medical procedure/treatment. The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Clinican: Date: / /

MM DD YEAR

Part 4. Co-signer Attestation

If the evaluation has been performed by other than a New York State Licensed Psychiatrist or Psychologist, this form just be CO-SIGNED below.

Print Last Name:	Print First Name:
Check all that apply: ☐ NYS Licensed Psychiatrist ☐ NYS Licensed Psychologist	Professional License Number:

I concur with the above clinical evaluation. The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Physician/Licensed Psychologist: Date: / /

MM DD YEAR