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

Supplemental Medical Information 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.

Please attach: consults, progress notes, annual physical exam, results of diagnostic tests and other documentation related to the proposed major medical treatment(s) being requested.

For SDMC Use Only:

Part 1. Patient Information

Last Name:	First Name:

Part 2. Current Medications

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

Current medication	Dosage	Frequency	Mode of Intake

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

Part 3. Allergies

Any known allergies?

Patient Last Name:

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: _____

b. List any abnormal findings from exams and tests: ☐ **N/A**

c. Date of most recent EKG. Include a copy. ☐ **N/A**

Date: _____

d. Date of most recent chest x-ray. Include a copy. ☐ **N/A**

Date: _____

e. Date of most recent laboratory tests. Include a copy of the most recent lab work.

Date: _____

Part 5. Additional Information

a. List any cardiac or pulmonary condition(s): ☐ **N/A**

b. List any major illness, surgery, and/or hospitalizations in the last year: ☐ **N/A**

c. List any other known physical conditions or medical diagnoses: ☐ **N/A**

Part 6. Anesthesia

Has the patient had general anesthesia before? ☐ Yes ☐ No ☐ Unknown
(Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.)

Patient Last Name:

For SDMC Use Only:

Part 7. Schedule

Is the requested procedure(s) scheduled? ☐ **Yes** **Date:** _____ ☐ **No**

The standard consent period is 60 days from the date of the hearing. Is 60 days sufficient? ☐ **Yes** ☐ **No**

If a longer consent is required, please indicate the time frame requested and the reason for the request.

Consent period being requested:

☐ **90 days** ☐ **120 days** ☐ **180 days** ☐ **365 days**

Reason for the request: ☐ **Medical** ☐ **Scheduling**

Part 8. Prior SDMC Review

Has the patient been previously reviewed by SDMC? ☐ **Yes** ☐ **No** ☐ **Unknown**

Part 9. Form Submitter's Contact Information

Print Last Name:		Print First Name:	
Email Address:			
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Part 10. Attestation

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

Signature of Form Submitter: Date: / /

MM DD YEAR

PLEASE REMEMBER TO ATTACH

Documentation related to the proposed major medical treatment(s) being requested:

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