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

Form Checklist for End of Life Care Decisions

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

To avoid delays in case processing, all SDMC forms must be completed and all required supporting documents submitted together.

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

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Be sure to include fully completed:

- ☐ **SDMC Form 300** Declaration for End of Life Care
- ☐ **SDMC Form 310** Certification on Capacity for End of Life Care
- ☐ **SDMC Form 320A-B** Attending Physician and Concurring Physician Certification for End of Life Care
- ☐ **SDMC Form 330** Supplemental Medical Information for End of Life Care

Other required documents related to the procedure:

- ☐ Annual Physical Exam (Most recent annual physical)
- ☐ Most current lab work
- ☐ Most current EKG (If available)
- ☐ Most current chest x-ray (If available)
- ☐ Physician's consult, office notes, scripts, etc.
- ☐ Any other diagnostic testing or related procedures

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.

Please contact SDMC with any questions at (518) 549-0328.

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

Declaration for End of Life Care

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

All Parts of this form must be completed. Type or print in black ink.

Part 14 – Declarant must sign and date where indicated.

Please avoid the use of abbreviations.

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Part 1. Patient Information

Last Name:		First Name:	
Date of Birth:	Age:	Religion:	Sex: ☐ MALE ☐ FEMALE
Street Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
County of Residence:			

Type of Residence

☐ Intermediate Care Facility ☐ Family Care ☐ Individualized Residential Alternative (IRA) ☐ Nursing Home

☐ Community Residence ☐ Developmental Center ☐ Assisted Living ☐ Adult Home ☐ Waiver

☐ Other Services: _____

Part 2a. Declarant

The declarant should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interest for this specific case.

Last Name:		First Name:	
Title:		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 ( )

Patient Last Name:

For SDMC Use Only:

Part 2b. Alternate Declarant
The alternate declarant will be contacted if the declarant is not available and should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interests for this specific case.

Last Name:		First Name:	
Title:		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 3. Other Service Providers
Provide information relating to other service providers that are involved in the care of this patient

Part 3a. Nurse

Last Name:		First Name:	
Title:		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 3b. Residential Manager or Director | Family Care Liaison

Last Name:		First Name:	
Title:		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 ( )

Patient Last Name:

For SDMC Use Only:

Part 3c. Service Coordinator | Social Worker			
Last Name:		First Name:	
Title:		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 3d. Hospice Contact			
Last Name:		First Name:	
Title:		Business 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 3e. Hospital | Nursing Home Contact Provide the following information if the patient has been transferred to a hospital, rehabilitation center or nursing home.			
Last Name:		First Name:	
Title:		Business Email Address:	
Hospital | Nursing Home Name:			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )
Pager: (Include area code)		Patient's Room Number:	

Part 4. What agency operates the Day Program?

(Please avoid abbreviations)

Patient Last Name:

For SDMC Use Only:

Part 5. Other Agencies

Agency Name(s):
List any other agencies providing services not previously mentioned.

Part 6a. Legally Authorized Surrogates
Provide the following information for known surrogates.

Status of the patient's mother: ☐ Living (List below) ☐ Deceased ☐ Whereabouts Unknown

Status of the patient's father: ☐ Living (List below) ☐ Deceased ☐ Whereabouts Unknown

Check all that apply and list in the box below:
☐ Parent ☐ Spouse ☐ Adult Child
☐ Health Care Proxy ☐ Guardian

Are there any actively involved adult family members that have a significant and on-going relationship with the patient sufficient enough to know the care needs of the patient? ☐ **YES** list in the box below ☐ **NO** proceed to Part 8

For any surrogate listed below, please explain why they do not wish to provide informed consent:

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment.
☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?
☐ Phone ☐ Mail ☐ Email ☐ In Person
☐ Unable to contact ☐ Other: _____

Patient Last Name:

For SDMC Use Only:

Part 6b. Legally Authorized Surrogates
Provide the information for any additional surrogates.

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment.

☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Part 6c. Legally Authorized Surrogates
Provide the information for any additional surrogates.

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment.

☐ Does not wish to make decision ☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Patient Last Name:

For SDMC Use Only:

Part 7a. Correspondents, Community Advocates or Family Care Provider(s)

☐ **N/A** proceed to Part 8

Correspondent means a person who has demonstrated a genuine interest in promoting the best interests of the patient by having a personal relationship with the patient, by participating in the patient's care and treatment, by regularly visiting the patient, or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)].

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment.

☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Unable to contact ☐ Other: _____

Part 7b. Correspondents, Community Advocates or Family Care Provider(s)

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Fax: Include area code ( )	Cell: Include area code ( )

Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment

☐ Agree ☐ Disagree ☐ No Opinion

How contacted?

☐ Phone ☐ Mail ☐ Email ☐ In Person

☐ Other: _____

Patient Last Name:

For SDMC Use Only:

Part 8. Visit

If the patient cannot attend the hearing, he or she will be visited by at least one panel member. Hospitalized patients are visited. Please explain the medical condition that would prevent the patient from attending the hearing:

Part 9. Supporting Documentation

As the Declarant, I have read the Certification on Capacity for End of Life Care (SDMC Form 310) stating that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician	☐ **YES**
and a Consulting Physician or NYS Licensed Psychologist.	☐ **YES**
As the Declarant, I have read the Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B) describing the patient's medical condition, the risks, benefits and alternative(s) to the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Concurring Physician.	☐ **YES**

Part 10a. Proposed Withholding

The proposed withholding of life sustaining treatment(s) is/are as follows:
See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B).

Part 10b. Proposed Withdrawal

The proposed withdrawal of life sustaining treatment(s) is/are as follows:
See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B).

Part 10c. Artificial Nutrition and/or Hydration

Has the physician requested to withhold / withdraw life-sustaining artificially provided nutrition or hydration for the patient? ☐ **YES** ☐ **NO**

Patient Last Name:

For SDMC Use Only:

Part 11. Hospice	
Is a Hospice admission anticipated? If the patient has been evaluated by Hospice, please attach the evaluation.	☐ **YES** ☐ **NO**

Part 12. Additional Information
List the title of the person who explained the proposed treatment decision to the patient.
Describe the efforts to determine the moral and religious beliefs of the patient, and the patient's reaction when the proposed withholding/withdrawal of life sustaining treatment(s) was/were explained.
Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment.
Based on your personal knowledge of this patient, explain in your own words why you believe the proposed treatment decision(s) is/are in the best interest of the patient.

Patient Last Name:

For SDMC Use Only:

Part 13. Communication Needs

Does the patient understand English? ☐ **YES** ☐ **NO**

Does the patient speak English? ☐ **YES** ☐ **NO**

If the patient is a non-English speaker, please indicate the language they speak or understand: _____

Does the patient require an interpreter? ☐ **YES** ☐ **NO**

If YES, please indicate type (foreign language, sign language, other):

Does the patient use a communication board or other assistive device? ☐ **YES** ☐ **NO**

If YES, please indicate type of assistive device:
Please ensure that such device is brought to the hearing.

Is the patient able to verbally communicate their needs? ☐ **YES** ☐ **NO**

Is the patient able to demonstrate an understanding of verbal communications? ☐ **YES** ☐ **NO**

How do they communicate their needs?

Part 14. Attestation

This request is based on the patient's qualifying medical condition other than intellectual or developmental disability, with recognition that a person with an intellectual or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without intellectual or developmental disabilities and without any financial considerations that affect the health care provider or any other party.

The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Declarant: Date: ____/____/____

MM DD YEAR

NOTE:
This form must be dated the same or later than the other forms in this case. This includes the:

- Certification on Capacity for End of Life Care (SDMC Form 310);
- Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B);
- Supplemental Medical Information for End of Life Care (SDMC Form 330).

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.