Justice Center for the Protection of People with Special Needs

Attending Physician and Concurring Physician Certification for End of Life Care

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 10 – Attending Physician AND Concurring Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

The withholding or withdrawing of life sustaining treatment is requested within 10 days. ☐ **YES** ☐ **NO**

If YES, you must state the medical facts to support the request.

Part 2. 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 3a. Attending Physician			
Last Name:		First Name:	
Professional License Number:			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Cell: Include area code ( )	Fax: Include area code ( )
Part 3b. Concurring Physician			
Last Name:		First Name:	
Professional License Number:			
Business Address:			
City:		State:	Zip:
Phone: Include area code ( )	Ext:	Cell: Include area code ( )	Fax: Include area code ( )

Patient Last Name:

For SDMC Use Only:

Part 4. Attending and Concurring Physician Findings

As a result of my examination, I have determined, to a reasonable degree of medical certainty, that the patient has been diagnosed with the following medical conditions:

Check all that apply; at least one box must be checked:

☐ A terminal condition where 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. Briefly describe

____

____; or

☐ Permanent unconsciousness; or

☐ A medical condition, other than intellectual or developmental disability which requires life-sustaining treatment, is irreversible, and which will continue indefinitely. Briefly describe

____

____

Signature of Attending Physician:	Date: ____ / ____ / ____ (MM / DD / YEAR)
Date of Review or Examination of Patient:	____ / ____ / ____ (MM / DD / YEAR)

Signature of Concurring Physician:	Date: ____ / ____ / ____ (MM / DD / YEAR)
Date of Review or Examination of Patient:	____ / ____ / ____ (MM / DD / YEAR)

Patient Last Name:

For SDMC Use Only:

Part 5. Attending and Concurring Physician Request to Withhold/Withdraw LST

Instructions:

Parts 5a-e Completed by the Attending Physician and reviewed by Concurring Physician.

The Concurring Physician may note additional comments regarding the life sustaining treatment and/or the burden of treatment for this patient.

a. **Based on the patient's medical diagnosis, I request consent to WITHHOLD the following life-sustaining treatment(s).** Please provide the exact wording that should be written on the SDMC consent form.
(To WITHHOLD treatment means to not initiate or provide treatment.)

	MUST CHECK YES OR NO	
DNR Order: Do not attempt Resuscitation	☐ **YES**	☐ **NO**
DNI: Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs.	☐ **YES**	☐ **NO**
Withhold future hospitalizations unless pain or severe symptoms cannot otherwise be controlled	☐ **YES**	☐ **NO**
Withhold Antibiotics	☐ **YES**	☐ **NO**
Withhold Vasopressors to support blood pressure	☐ **YES**	☐ **NO**
Withhold IV Fluids	☐ **YES**	☐ **NO**

Please list any additional life-sustaining treatment that should be withheld:

____

____

Based on the patient's medical diagnosis, I request consent to WITHDRAW the following life-sustaining treatment(s). Please provide the exact wording that should be written on the SDMC consent form.
(To WITHDRAW treatment means to stop or remove treatment.)

	MUST CHECK YES OR NO	
Withdraw Mechanical Ventilation	☐ **YES**	☐ **NO**
Withdraw Antibiotics	☐ **YES**	☐ **NO**
Withdraw Vasopressors to support blood pressure	☐ **YES**	☐ **NO**
Withdraw IV Fluids	☐ **YES**	☐ **NO**

Please list any additional life-sustaining treatment that should be withdrawn:

____

____

Patient Last Name:

For SDMC Use Only:

b. I find that the life-sustaining treatment(s) listed above would impose an EXTRAORDINARY BURDEN on the patient in light of the patient's medical condition.
(Please describe the EXTRAORDINARY BURDEN the above life-sustaining treatments pose to the patient. If available, list any test or supporting information that confirm your findings. Include copies of medical records, progress notes, consultations or other relevant reports.)

____

____

____

____

____

c. Is this a request to WITHHOLD or WITHDRAW life-sustaining artificially provided nutrition or hydration for the patient? ☐ **YES** ☐ **NO**

If YES, I find to a reasonable degree of medical certainty that:

☐ There is no hope of maintaining life; or

☐ The artificially provided nutrition or hydration would impose an extraordinary burden on the patient.

d. **If reasons to withhold and/or withdraw life sustaining artificially provided nutrition differ from 5b above, describe the EXTRAORDINARY BURDEN of providing artificial hydration or nutrition to the patient, and any diagnostic testing/examinations that confirm this recommendation.** Include copies of reports.

____

____

____

____

____

e. Do you anticipate a Hospice admission? ☐ **YES** ☐ **NO**
If YES, include the hospice evaluation with the submission of this form, if available.

Patient Last Name:

For SDMC Use Only:

Part 6. Expected Outcome
Describe the expected outcome of providing or continuing life-sustaining treatment(s) to the patient and, if available, list any tests or information that confirms these findings. Include copies of medical records, progress notes, consults or other relevant reports.

____

____

____

____

____

Part 7. Alternatives

Is there an alternate procedure available to this patient that will preserve, improve or restore the patient's health? ☐ **YES** ☐ **NO**

If YES, please state the procedure:

____

Please explain the rejection of this alternate procedure:

____

Patient Last Name:

For SDMC Use Only:

Part 8. Justification by Attending Physician
In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:
____
____
____
____
____

Part 9. Justification by Concurring Physician
In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:
____
____
____
____
____

Part 10. Attestation **(Attending Physician and Concurring Physician must sign and date the attestation)**		
The above information and statements are given to the best of my knowledge, complete and truthful.		
Signature of Attending Physician:	Date:	/ / MM DD YEAR
Signature of Concurring Physician:	Date:	/ / MM DD YEAR