

SERIES 200 FORMS

1. Changes to the 200 form - Declaration for Surrogate Decision-Making has been modified in several ways:
 - a. Question 2 on page 1 was slightly modified to include the statement "If yes, list organization/agency names". The SDMC program was getting a number of responses to this question that were not required such as attends day treatment or workshop offered by the same agency as the patient's residence. The slight wording is intended to add clarity to the information we are trying to solicit.
 - b. Question 5b on page 2 now asks for the status of the patient's mother and father separately. Formerly the question only asked about the status of parents without distinguishing between the two.
 - c. Question 6b on page 2. While the form does not indicate it yet, we are thinking about information on MSC's since these individuals no longer work for the DDSO. Ombudsman who previously worked for OPWDD now work for the Justice Center, and we will likely include them in our notifications of hearing.
 - d. Question 6c on page 3 – Reference to CAB Representatives has been deleted because we have not seen a case for a patient with a CAB Representative since OPWDD regulations have been modified.
 - e. With the elimination of question 6c, the former statement is no longer 6d and moves up to 6c.
 - f. On page 4 Questions 8 and 12 have been slightly modified to include the statement "As the declarant I have read . . ." in an effort to ensure that the declarant is aware of what is presented in the entire case and improve preparation to give testimony about the case.
 - g. Question 13 on page 4 regarding obtaining a second opinion has been deleted from this form and was moved to the 220-B form, Supplemental Medical Information. The person completing the 220-B form is responsible to review the medical record and would be more apt to have the information regarding whether or not a second opinion was obtained.
 - h. Question 16b on page 5 has been expanded to include specific types of special communication needs in order to ensure that the patient's needs are addressed prior to and during the hearing.
 - i. Question 16 on page 5 regarding "Willowbrook Class Client" has been eliminated.
2. There have been no changes to the 210 forms – Certification on Capacity.

3. Changes to the 220-A form – Certification on Need for Major Medical Treatment – has been modified in several ways:
 - a. On page 1 Questions 4 and 5A have been collapsed into one question (4a) that now will read “On (date) I examined/reviewed (patient’s name). As a result of my examination and review of the medical record, I request informed consent for the following major medical treatment(s):
 - b. On page 2 Question 6a is designed to replace the diagnosis on the former page 1 question 4 and now reads “clinical indications for the requested proposed major Medical Treatment(s).”
 - c. Question 7a and 7c regarding the use of general anesthesia have been eliminated. Page 2 question 7 now reflects whether or not the use of general anesthesia is anticipated. As many procedures such as dental under IV sedation, HIV, etc. become more common the doctor’s are reporting back to us that they won’t answer what were questions 7a and 7c in those cases. The doctor’s leave the information blank or put non-applicable and obtaining this information creates delays in case preparation which ultimately impacts on the timeliness of patient care. At the same time the risks of general anesthesia are listed in every case in order to maintain an agreement with MHLS to consider the risks of general anesthesia in each case so that the wording of the 280-A consent form does not need to be limited or modified based on the form of anesthesia requested.

4. Changes to the 220-B form are as follows:
 - a. Question 7 on page 1 has been added asking if there has been a second opinion, and if so, was it for capacity and/or best interest?
 - b. Question 13 on page 3 is expanded to prompt the provider to ask the treating physicians, dentists, or podiatrists about how long they are scheduling out, so the panel may consider this information in determining whether an extension beyond the standard 60 days of the consent period should be granted.
 - c. Question 15 on page 3 has been added so that the SDMC Program has advance knowledge of where the patient is located, where the hearing should be held and include the patient’s residential staff as correspondents, if they are not the declarant.

SERIES 300 FORMS

1. Changes in the 300 form – Declaration for Health Care Decisions Act
 - a. Question 2 on page 1 the language was slightly modified to include the statement “If yes, list organization/agency names.” The SDMC program was getting a number of responses to this question that were not required such as attends day treatment or workshop offered by the same agency as the patient’s residence. The slight wording is intended to add clarity to the information we are trying to solicit.
 - b. Question 5b on page 2 now asks for the status of the patient’s mother and father separately. Formerly the question only asked about the status of the parents without distinguishing between the two.
 - c. Question 6c on page 3 now requests contact information for a Hospice coordinator if the MD check yes for Hospice Admission on question 6 of the 320-A or 320-B forms. There have been a number of hearings where there are questions, many raised by MHLS, regarding the types of services and care that will be offered while the patient is on hospice. In the vast majority of the cases the house staff providing testimony can answer those questions. However, there have been other times that the testimony of a Hospice representative would prove to be valuable. Listing the Hospice coordinator will allow for them to receive notice and to participate in the hearing as a correspondent. Also, in Question 6c on page 3 – Reference to CAB Representative has been deleted because we have not seen a case for a patient with a CAB Representative since OPWDD regulations have been modified. As stated earlier we are contemplating including MSC’s and Ombudsman as correspondents in the case.
 - d. Question 8 and 11 on page 4 have been modified slightly to include the statement “As the declarant I have read” in an effort to ensure that the declarant is aware of what is presented in the entire case and improve preparation to give testimony about the case.
 - e. Question 10 on page 4 regarding whether Hospice is anticipated the response of “unknown” has been eliminated. We have found that doctors are unsure about what will happen when life-sustaining treatment is withheld. At one time we used the terminology “possible Hospice” in the consent to address such situations to encourage the MD’s to say yes or no to the Hospice question. Although there have been no formal objections, different MHLS attorneys from across the state have told us that they feel that this response was not adequate. After listening, we have decided to remove “unknown” as a response.
 - f. Question 14b on page 5 has been expanded to include specific types of special communication needs in order to ensure that the patient’s needs are addressed prior to and during the hearing.
2. There have been no changes to the 310 – Certification on Capacity.
3. The following changes have been made to the 320-A and the 320-B forms (Attending Physician Certification and Concurring Physician Certification):

- a. On page 1 question 4 the statement has been modified to include: (must check one or all that apply). SDMC has been receiving requests for DNR/DNI for patients who do not have a qualifying condition per Article 17-A, Section 1750-b of SCPA. In other cases this section has been left blank requiring another phone call to the declarant or patient's physician.
 - b. Question 6 on page 2 regarding whether Hospice is anticipated the response of "unknown" has been eliminated. We have found that doctors are unsure about what will happen when life-sustaining treatment is withdrawn/withheld. Hopefully this change will increase the likelihood that the MD will address this question. Also, at one time we used the terminology "possible Hospice" in the consent to address the "unknown" response. Although there have been no formal objections, different MHLS attorneys from across the State have told us that they feel that this response was not adequate. After listening to interested parties, we have decided to remove "unknown" as a response.
4. There have been no changes to the 330 form – Supplemental Medical Information.

SDMC Hearing Forms – Modifications

1. The 272 Outcome of Medical Procedure Form. SDMC has listened to concerns raised by MHLS regarding conducting conference calls rather than sending the request to a new hearing for treatments that are more invasive than the originally proposed treatment for which consent was provided. While SDMC will continue to work with MHLS regarding each situation as it arises, SDMC retains the authority to conduct conference calls as the situation dictates, including: the urgency of the care needs of the patient, a scheduled procedure date that would otherwise have to be postponed creating an unreasonable delay in care, the follow-up is less invasive than the original treatment and other situations that arise.
2. The 272-H Outcome of Medical Procedure HIV Testing Form. SDMC has modified the form so that the patient's name no longer appears anywhere on the form. In order to maintain the patient's confidentiality, the only identifying information will be the declaration number. Also, a statement that the care provider should contact SDMC if additional care is required. While SDMC will continue to work with MHLS regarding each situation as it arises, SDMC retains the authority to conduct conference calls as the situation dictates, including: the urgency of the care needs of the patient, a scheduled procedure date that would otherwise have to be postponed creating an unreasonable delay in care, the follow-up is less invasive than the original treatment and other situations that arise.
3. The 380-A Consent to Withdraw/Withhold Life Sustaining Treatment form. We have eliminated expiration dates in these cases. Since the amendment to the definition of Life Sustaining Treatment was made to include CPR, OPWDD requires that all new orders for DNR/DNI follow the guidelines set out by 1750-b. Although it has not happened frequently, we have seen several cases where the patient with a DNR/DNI order has lived beyond the one-year time frame of the consent. In evaluating this situation, we have taken the position that we do not have the authority to care plan on behalf of the patient. Further, in other settings, the decision to review a DNR/DNI order and extend it is in the hands of the Attending Physician. We strongly feel that we should adopt a similar approach and we have added language to the 380-A Form that states that the decision shall remain in effect as long as the patient has a qualifying medical condition as determined by the Attending Physician.

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF THE NEED FOR
SURROGATE DECISION-MAKING ON BEHALF OF**

**DECLARATION FOR
SURROGATE
DECISION-MAKING**

(Patient's Name)

Declaration # (SDMC Use Only)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

To the Surrogate Decision-Making Committee:

1a. I am the Declarant for the above named individual; my name, work address and telephone numbers are:

Name: _____ Title: _____

Agency/Organization Name: _____

Full Mailing Address: _____

(We will contact you regarding this declaration. Please list contact information where you can be reached Monday through Friday, during regular business hours.)

Work Phone () _____ EXT. _____

Work FAX () _____

Beeper () _____

Work Cell () _____

Email _____

1b. My relationship with the patient is (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Direct Care Staff | <input type="checkbox"/> Family Care Provider | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Service Coordinator | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse | <input type="checkbox"/> Residence Manager |
| <input type="checkbox"/> Executive Director | <input type="checkbox"/> Physician/Dentist/Podiatrist | <input type="checkbox"/> Other: _____ |

2. Does the patient receive services from any outside OPWDD, OMH, or OASAS organization/agency?

Yes No

If yes, list organization/agency names: _____

3. Who explained the proposed major medical treatment(s) to the patient?

(Title Only) _____

4. Describe the patient's reaction when the proposed major medical treatment(s) was/were explained, and any opinions expressed: _____

****DO NOT STAPLE FORMS****

- 5a. Are there any known Legally Authorized Surrogates as specifically identified in Article 80 of the Mental Hygiene Law? Yes No If yes, check all that apply. Parent Spouse Adult Child Guardian/Conservator/Committee of the Person Health Care Proxy
- 5b. Indicate the status of the patient's mother. Living Deceased Whereabouts Unknown
Indicate the status of the patient's father. Living Deceased Whereabouts Unknown
- 5c. Provide the following information for **anyone living listed above**. Explain all of your answers.

<p>Name: _____ Address: _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>
<p>Name: _____ Address: _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>

****DO NOT STAPLE FORMS****

6a. Are there any known actively involved adult siblings, or other family members, who are unavailable, do not wish to make the decision or are not authorized to make the decision?

Yes No If yes, list below.

6b. Are there any correspondents, community advocates or a FAMILY CARE PROVIDER?

Yes No If yes, list below.

6c. For current or former OPWDD patients **ONLY**: If the patient has one or more actively involved sibling or other adult family member explain why surrogate decision-making is needed (e.g.: family members are unavailable, family members do not wish to make the decision and/or they want SDMC to resolve a possible objection or difference of opinion). **Explain all of your answers.**

<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>

7. For persons listed in sections 5 and 6 who were not able to be contacted, please list what efforts were made to contact them to discuss this case.

8. As the Declarant, I have read SDMC Form 210 (Certification on Capacity) that has been completed by _____ and signed on _____
(Name of Psychiatrist or Psychologist) (Date)
indicating his/her professional opinion that the patient does not have the capacity to provide informed consent for the proposed major medical treatment(s).

9. The proposed major medical treatment(s) is/are as follows (per SDMC Form 220-A, #4a and 4b):

10. Is the use of general anesthesia anticipated? ___ Yes ___ No (per SDMC Form 220-A, #7)

11. Is an HIV test being requested? ___ Yes ___ No (per SDMC Form 220-A, #5)

12. As the Declarant, I have read SDMC Form 220-A (Certification of Need for Major Medical Treatment) that has been completed by _____ and signed on _____ describing the patient's medical/dental condition, the proposed major medical treatment(s), the risks, benefits and alternative(s) to the proposed procedure.
(Name of Physician/ Dentist/Podiatrist)
(Date)

13. In my opinion, the patient cannot give informed consent for this procedure because:

14. In my opinion, the proposed major medical treatment(s) is/are in the best interest of the patient because:

15. This declaration is made on behalf of:

a. Patient's Name: _____

Address: _____

Phone: () _____

(Phone Number of Patient's Residence)

c. Type of Residence: _____ ICF _____ CR

_____ DC _____ FC _____ IRA _____ CW

_____ PC _____ Hospital Psychiatric Ward

_____ Nursing Home _____ Adult Home

_____ Assisted Living _____ Waiver Services

_____ OMH funded or approved housing

_____ Other: _____

b. Date of Birth: _____ / _____ / _____

(Month Day Year)

Age: _____

Sex: _____ Male _____ Female

Religion: _____

Primary Language: _____

Does the patient have special communication needs?

_____ Yes _____ No

If Yes, what type: _____ foreign language

_____ communication board or other assistive device

_____ sign language interpreter _____ other

d. County of Residence: _____

16. Name of Second Contact: _____ Title: _____

(An alternate contact to Declarant must be provided.)

Second Contact's Full Mailing Address (Organization Name): _____

Street

City

State

Zip

Work Phone () _____

EXT. _____

FAX Phone () _____

Beeper () _____

Work Cell () _____

Email _____

17. To the best of my knowledge, the above information and statements are truthful and complete.

Print Declarant's Name Clearly

Declarant's Signature

Date

NOTE: This form must be dated the same or later than the other SDMC Forms in the case.

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF THE NEED FOR
SURROGATE DECISION-MAKING ON BEHALF OF**

**CERTIFICATION
ON CAPACITY**

(Patient's Name)

Declaration # (SDMC Use Only)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

1. I, _____, am a _____,
(Clinician's Name) (Psychiatrist or Psychologist)
duly licensed to practice in the State of New York and my professional New York State License Number
is _____.

2. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

3. On _____, I examined/interviewed _____.
(Date) (Patient's Name)

As a result of this examination/interview, I have diagnosed that he/she has the following mental disability:

Diagnosis: _____

4. If available, list any recent psychological tests results and/or the patient's IQ/Mental Age.
(NOTE: testing is not necessary to complete this form.)

- 5. Summarize your 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.

It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding this major medical procedure/treatment.

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

Print Name Clearly	Signature
	Date

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

- 7. I am a NYS licensed _____ . I concur with the above clinical evaluation and certify that it is complete and truthful to the best of my knowledge.
(Psychiatrist or Psychologist)

Print Name Clearly	Signature
NYS License Number	Date

5. Do you anticipate performing an HIV test? _____ Yes _____ No

Public Health Law section 2781 (3) requires that the person ordering the HIV test must provide counseling and information regarding HIV testing risks and benefits to the patient to the extent possible. These include:

- (a) HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants;
- (b) there is treatment for HIV that can help an individual stay healthy;
- (c) individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV;
- (d) testing is voluntary and can be done anonymously at a public testing center;
- (e) the law protects the confidentiality of HIV related test results;
- (f) the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and
- (g) the law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

6a. Clinical indications for the requested proposed major medical treatment(s):

6b. In my clinical opinion the **risks** specific to this proposed major medical treatment(s) is/are:

6c. In my clinical opinion the **benefits** specific to this proposed major medical treatment(s) is/are:

7. Is the use of general anesthesia anticipated? _____ Yes _____ No

Only answer YES if the patient will be unconscious and intubated during the treatment.

When the treatment plan does not include general anesthesia, if on the day of the proposed major medical treatment(s) the use of general anesthesia becomes necessary, Public Health Law Section 2805-d provides for the disclosure of reasonably foreseeable risks. Common/severe complications of general anesthesia include: hoarseness, nausea, sore throat, broken teeth, tracheal or esophageal injuries, respiratory distress, cardiac failure and death.

(Source: American Society of Anesthesiologists)

8. The following diagnostic tests/examinations have been performed to confirm my recommendation(s):
(Include copies of reports.) _____

9. Is there an alternative less-invasive procedure available to this patient? _____ Yes _____ No

If yes, state procedure: _____

Explain your rejection of this alternative procedure below:

10. Explain the **risk of non-treatment**: _____

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

Print Name Clearly

Signature

Date

If the evaluation has been performed by other than a licensed physician, dentist or podiatrist, this form must be co-signed below.

12. I am a licensed _____ . I concur with the above clinical evaluation and certify that
(Physician/Dentist/Podiatrist)
it is complete and truthful to the best of my knowledge.

Print Name Clearly

Signature

License #

Date

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF THE NEED FOR
SURROGATE DECISION-MAKING ON BEHALF OF

SUPPLEMENTAL MEDICAL
INFORMATION

(Patient's Name)

Declaration # (SDMC Use Only)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

1a. Current medications, dosages, frequency and mode of intake:

1b. List any drugs requiring frequent blood level monitoring. (Include copy)

2. Any known allergies: _____

3. Annual physical examination: _____ (Must include copy)
(Date)
Abnormal findings: _____

4. Most recent EKG: _____ (Include copy, if available)
(Date)

5. Most recent Chest X-ray: _____ (Include copy, if available)
(Date)

6. Most recent laboratory tests: _____ (Include copy, if available)
(Date)

7. Has there been a second opinion? If so what type? _____ Capacity _____ Best Interest

8. List any cardiac or pulmonary condition(s): _____

9. List any major illness, surgery and/or hospitalizations in the last year:

10. List any other known physical conditions: _____

11. Has this patient had general anesthesia before? Yes No Unknown
Date of most recent general anesthesia: _____
Any history of adverse reactions to general anesthesia? Yes No Unknown

**IV sedation and MAC are not considered general anesthesia for SDMC cases.*

If yes, describe: _____

12. MHL Article 80 requires the patient to be present at the hearing. Is there any medical condition that would prevent the patient from attending the hearing? Yes No

If yes, explain: _____

13. Is the requested procedure(s) scheduled? Yes No
If yes, date: _____ If no, when is the anticipated scheduled date? _____

14. Has the patient been reviewed by SDMC previously? Yes No Unknown
If yes, answer the following (if known):

a. Date most recent SDMC approved procedure performed: _____

b. Procedure(s) previously requested: _____

c. Results of procedure(s): _____

15. If the patient has been transferred to a healthcare facility other than their residence, please provide the following information:

Facility Name: _____

Facility Address: _____

Facility Contact Person: Name: _____

Contact's Phone #: () _____ Patient's Room #: _____

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

Print Name Clearly

Signature

Title

Date

Work Phone: () _____

Work Cell: () _____

Work Fax: () _____

PLEASE REMEMBER TO ATTACH:

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

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT**

**DECLARATION FOR
HEALTH CARE
DECISIONS ACT**

(Patient's Name)

Declaration # (SDMC Use Only)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

To the Surrogate Decision-Making Committee:

1a. I am the Declarant for the above named individual; my name, work address and telephone numbers are:

Name: _____ Title: _____

Organization Name: _____

Full Mailing Address: _____

(We will contact you regarding this declaration. Please list contact information where you can be reached.)

Work Phone () _____ EXT. _____

Work FAX () _____

Beeper () _____

Work Cell () _____

Email _____

1b. My relationship with the patient is (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Direct Care Staff | <input type="checkbox"/> Family Care Provider | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Service Coordinator | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse | <input type="checkbox"/> Residence Manager |
| <input type="checkbox"/> Executive Director | <input type="checkbox"/> Physician/Dentist | <input type="checkbox"/> Other: |

2. Does the patient receive services from any outside OPWDD, OMH, or OASAS organization/agency?

Yes No

If yes, list organization/agency names: _____

3. Who explained the proposed withholding/withdrawal of life sustaining treatment(s) to the patient? _____ (Title Only)

4. 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.

5a. Are there any known Legally Authorized Surrogates specifically identified by Article 80 of the Mental Hygiene Law? Yes No If yes, check all that apply. Parent Spouse Adult Child Guardian/Conservator/Committee of the Person Health Care Proxy

5b. Indicate the status of the patient's mother. Living Deceased Whereabouts Unknown
Indicate the status of the patient's father. Living Deceased Whereabouts Unknown

5c. Provide the following information for **anyone living listed above**. **Explain all of your answers.**

<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>

****DO NOT STAPLE FORMS****

- 6a. Are there any known actively involved adult siblings, or other family members, who do not wish to make the decision? Yes No If yes, list below.
- 6b. Are there any correspondents, community advocates or a FAMILY CARE PROVIDER?
 Yes No If yes, list below.
- 6c. If physician checked Yes to HOSPICE (Ques. #6 on SDMC Form 320-A), include contact information for HOSPICE Coordinator below.
- 6d. If the patient has one or more actively involved siblings or other adult family members, explain why surrogate decision-making is needed (e.g.: family members are unavailable, family members do not wish to make the decision and/or they want SDMC to resolve a possible objection or difference of opinion).
Explain your answers.

<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____</p>

7. For persons listed in sections 5 and 6 who were not able to be contacted, please list what efforts were made to contact them to discuss this case.

8. As the Declarant, I have read SDMC Form 310 (Certification on Capacity) completed by _____ and signed on _____
(Attending Physician) (Date)

and _____ and signed on _____
(Consulting Physician or Licensed Psychologist) (Date)

indicating his/her professional opinions that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s).

9. The proposed withholding/withdrawal of life sustaining treatment(s) is/are as follows (per #5a on SDMC Forms 320-A and 320-B):

10. Is hospice admission anticipated? _____ Yes _____ No (Per #6 on SDMC 320-A and 320-B)

11. As the Declarants, I have read SDMC Forms 320-A and 320-B (Attending Physician Certification and Concurring Physician Certification) completed by

_____ signed on _____
(Name of Attending Physician) (Date)

_____ signed on _____
(Name of Concurring Physician) (Date)

describing the patient's medical condition, the risks, benefits and alternative(s) to this/these withholding/withdrawal of life sustaining treatment(s).

12. In my opinion, the patient cannot give informed consent for this/these decision(s) because:

13. It is my opinion that the proposed decision(s) is/are in the best interest of the patient because:

14. This declaration is made on behalf of:

a. Patient's Name: _____

Address: _____

Phone: (_____) _____
(Phone Number of Patient's Residence)

b. Date of Birth: ____ / ____ / ____
(Month Day Year)

Age: _____

Sex: ____ Male ____ Female

Religion: _____

Primary Language: _____

Does the patient have special communication needs? ____ Yes ____ No

If Yes, what type: ____ foreign language
____ communication board or other assistive device
____ sign language interpreter ____ other

c. Type of Residence: ____ ICF ____ CR

____ DC ____ FC ____ IRA ____ CW

____ PC ____ Hospital Psychiatric Ward

____ Nursing Home ____ Adult Home

____ Assisted Living ____ Waiver Services

____ OMH funded or approved housing

____ Other: _____

d. County of Residence: _____

15. Name of Second Contact: _____ Title: _____

(An alternate contact to Declarant must be provided.)

Second Contact's Full Mailing Address (Organization Name): _____

Street City State Zip

Work Phone (_____) _____

EXT. _____

FAX Phone (_____) _____

Beeper (_____) _____

Work Cell (_____) _____

Email _____

16. This request is based on the patient's qualifying medical condition other than mental retardation or developmental disability, with recognition that a person with mental retardation or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without mental retardation or developmental disabilities and without any financial considerations that affect the health care provider or any other party. To the best of my knowledge, the above information and statements are truthful and complete.

Print Declarant's Name Clearly

Declarant's Signature

Date

NOTE: This form must be dated the same or later than the other SDMC Forms in the case.

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT ON BEHALF OF

**CERTIFICATION
ON CAPACITY**

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

A. STATEMENT OF ATTENDING PHYSICIAN

1. I, _____, am an attending physician for the patient,
(Print Physician's Name)
_____ and my professional License Number is _____
(Print Patient's Name)

2. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: () Fax: ()

3. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions.

The cause and nature of the patient's mental disability/incapacity (Diagnosis) is:

The extent and probable duration of this mental disability/incapacity is:

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

Signature of Attending Physician

Date

B. STATEMENT BY CONSULTING PHYSICIAN OR PSYCHOLOGIST

5. I, _____ am a _____
(Print Name) (Consulting Physician or Licensed Psychologist)
and my professional license number is _____.

6. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

7. On _____, I examined/interviewed _____
Date Patient's Name

As a result of this examination, I have diagnosed that he/she has the following mental disability

(Diagnosis – Cause and Nature of Incapacity)

8. The extent and probable duration of this mental disability/incapacity is: _____

9. If available, list any recent psychological tests, results and/or the patient's IQ/Mental Age.
(Note: Testing is not necessary to complete this form.)

10. Summarize your clinical evaluation, including the patient's reaction, when you explained the proposed withholding/withdrawal of life sustaining treatment(s) that validates your opinion regarding the patient's decision-making ability.

It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding the proposed withholding/withdrawal of life sustaining treatment(s).

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

Signature Consulting Physician/Licensed Psychologist

Date

**TO BE COMPLETED BY THE
ATTENDING PHYSICIAN OR CONSULTANT**

12. A request for a decision to withdraw or withhold life-sustaining treatment requires one of the above attending or consulting physicians or licensed psychologists to meet one of the following criteria

_____ is either (select at least one)
Print Name Physician/Licensed Psychologist

- employed by a developmental disabilities services office MHL § 13.17
- has been employed for a minimum of two years to render care and service in a program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD)
- has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD).

Signature Physician/Licensed Psychologist

Date

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT ON BEHALF OF

**ATTENDING PHYSICIAN
CERTIFICATION**

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

- 1a. Is an Expedited Review necessary? _____ Yes _____ No
- 1b. If an expedited case review is being requested, state the medical facts indicating its need. An expedited case review is where the patient's needs are urgent but not an emergency.

2. I, _____, am an attending physician for the patient and my
(Print Name)
professional license number is _____.

3. My office address and phone number are: _____
(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

4. On _____ I personally examined _____
(Date) (Patient's Name)

As a result of such examination, I diagnosed to a reasonable degree of medical certainty that the patient lacks capacity, has mental retardation or developmental disability and suffers from the following medical condition/s (**must check one or all that apply**):

- a terminal condition in that 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; or,
- permanent unconsciousness; or
- a medical condition other than mental retardation or developmental disability which requires life-sustaining treatment, is irreversible and which will continue indefinitely.

5a. Based on the medical diagnosis, I request consent to withhold/withdraw the following life-sustaining treatment(s) (write exact wording you want on the consent form):

Circle One

I find further that the life-sustaining treatment would impose an extraordinary burden on the patient **in light of the person's medical condition** other than the person's mental retardation or developmental disability.

5b. Describe the extraordinary burden of the life sustaining treatment(s) for the patient and, if available, list any tests or supporting information that confirm your findings (Include copies of reports):

5c. Describe the expected outcome of life-sustaining treatment(s) for the patient and, if available, list any tests or supportive information that confirms your findings (Include copies of reports.):

6. Do you anticipate hospice admission? _____ Yes _____ No

7a. Is this a request to withhold or withdraw life-sustaining artificially provided nutrition or hydration for the patient? _____ Yes _____ No (If no, proceed to Question 8.)

7b. If yes, I find to a reasonable degree of medical certainty that:

- there is no reasonable hope of maintaining life; or
- the artificially provided nutrition or hydration impose an extraordinary burden on the patient.

7c. If not the same as 5b above, describe the extraordinary burden of providing artificial nutrition and hydration and, if available, any diagnostic tests/examinations that have been performed to confirm my recommendations(s). (Include copies of reports.).

8. In my clinical opinion the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

9a. Is there an alternative procedure available to this patient that will preserve, improve, or restore the person's health? Yes No

9b. If yes, please state procedure: _____

9c. Please explain your rejection of this optional choice.

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

Print Name Clearly

Signature

Date

Please check to see that you have answered all questions.

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT ON BEHALF OF**

**CONCURRING PHYSICIAN
CERTIFICATION**

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

- 1a. Is an Expedited Review necessary? _____ Yes _____ No
- 1b. If an expedited case review is being requested, state the medical facts indicating its need. An expedited case review is where the patient's needs are urgent but not an emergency.

2. I, _____, am a physician for the patient, and my
(Print Name)
 professional license number is _____.

3. My office address and phone number are: _____
(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

4. On _____ I personally examined _____
(Date) (Patient's Name)

As a result of such examination, I diagnosed to a reasonable degree of medical certainty that the patient lacks capacity, has mental retardation or developmental disability and suffers from the following medical condition/s (**must check one or all that apply**):

- a terminal condition in that 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; or,
- permanent unconsciousness; or
- a medical condition other than mental retardation or developmental disability which requires life-sustaining treatment, is irreversible and which will continue indefinitely.

5a. Based on the medical diagnosis, I request consent to withhold/withdraw the following life-sustaining treatment(s) (write exact wording you want on the consent form):

Circle One

I find further that the life-sustaining treatment would impose an extraordinary burden on the patient **in light of the person's medical condition** other than the person's mental retardation or developmental disability.

5b. Describe the extraordinary burden of life sustaining treatment(s) for the patient and, if available, list any tests or supporting information that confirms your findings (Include copies of reports.):

5c. Describe the expected outcome of life-sustaining treatment(s) for the patient and, if available, list any tests or supportive information that confirms your findings (Include copies of reports.):

6. Do you anticipate hospice admission? _____ Yes _____ No

7a. Is this a request to withhold or withdraw life-sustaining artificially provided nutrition or hydration for the patient? _____ Yes _____ No (If no, proceed to Question 8.)

7b. If yes, I find to a reasonable degree of medical certainty that:

- there is no reasonable hope of maintaining life; or
- the artificially provided nutrition or hydration impose an extraordinary burden on the patient.

7c. If not the same as 5b above, describe the extraordinary burden of providing artificial nutrition and hydration and, if available, any diagnostic tests/examinations that have been performed to confirm my recommendations(s). (Include copies of reports.)

8. In my clinical opinion the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

9a. Is there an alternative procedure available to this patient that will preserve, improve, or restore the person's health? _____ Yes _____ No

9b. If yes, please state procedure: _____

9c. Please explain your rejection of this optional choice.

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

Print Name Clearly

Signature

Date

Please check to see that you have answered all questions.

SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT ON BEHALF OF

SUPPLEMENTAL MEDICAL
INFORMATION

Declaration # (SDMC Use Only)

(Patient's Name)

ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE

1a. Current medications, dosages, frequency and mode of intake:

1b. List any drugs requiring frequent blood level monitoring: (Include copy)

2. Any known allergies:

3. Most recent physical examination: _____ (Must include copy)
(Date)

Abnormal findings: _____

4 Most recent EKG: _____ (Date) (Include copy, if available)

5 Most recent Chest X-ray: _____ (Date) (Include copy, if available)

6. Most recent laboratory tests: _____ (Date) (Include copy, if available)

7. List any cardiac or pulmonary condition(s): _____

8. List any major illness, surgery and/or hospitalizations in the last year:

9. List any other known physical conditions: _____

10. If the patient has been transferred to a healthcare facility other than their residence, please provide the following information:

Facility Name: _____

Facility Address: _____

Facility Contact Person: Name: _____

Contact's Phone #: () _____ Patient's Room #: _____

11. Has the patient been reviewed by SDMC previously? ____ Yes ____ No ____ Unknown
If yes, answer the following (if known):

a. Date most recent SDMC approved procedure performed: _____

b. Procedure(s) previously requested: _____

c. Results of procedure(s): _____

12. The patient will be visited at least by one panel member.
Please explain the medical condition that would prevent the patient from attending the hearing:

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

Print Name Clearly

Signature

Title

Date

Work Phone: () _____

Work Cell: () _____

Fax: () _____

PLEASE REMEMBER TO ATTACH:

Consults, progress notes, annual physical exam, results of diagnostic tests and other documentation related to the proposed major medical treatment(s) decision.

REMINDER TO ATTENDING PHYSICIANS OF PATIENTS WITH MR/DD

Please take the following steps to implement consent to Withhold or Withdraw Life Sustaining Treatment:

For Consent(s) to **WITHHOLD** life sustaining treatment, provide notification to the following at the **earliest possible time** prior to implementing the decision.

AND/OR

For Consent(s) to **WITHDRAW** life sustaining treatment, provide notification to the following at least **48 hours** prior to implementation of the decision.

1. The Patient: except if the attending physician determines in writing and in consultation with another physician or licensed psychologist that, to a reasonable degree of medical certainty, the patient will suffer immediate and severe injury from such notification.
2. For a patient residing in or transferred from a residential facility or organization operated/licensed/approved by the Office for People with Developmental Disabilities (OPWDD):

- The DDSO Director or The Chief Executive Officer of that facility:

Name: «NDDD»

Phone#: «PDDD» «PDDDEXT»

Fax #: «FDDD»

AND

- Mental Hygiene Legal Services (MHLS):

Phone#: «PMH» «PMHEXT»

Fax #: «FMH»

3. For a patient is not residing in or was not transferred from a residence or organization as described in #2 above:

- The Commissioner of the NYS OPWDD, or their designee (DDSO Director)

Name: «NCOM»

Phone#: «PCOM» «PCOMEXT»

Fax #: «FCOM»

4. Include the decision in the patient's medical chart and either:

- Promptly issue an order to withhold or withdraw life sustaining treatment and inform the staff responsible for the patient's care, if any, of the order.

OR

- Promptly object to the decision.

5. Objections: Any of the following can stop the implementation of the decision either orally or in writing:

- Patient;
- Parent /Adult Sibling who has resided with or who has maintained substantial and continued contact with the patient;
- Attending MD/Other Licensed Health Care Practitioner providing services to the patient;
- The DDSO Director or CEO of the OPWDD licensed / operated /approved agency/organization where patient lives/lived;
- Mental Hygiene Legal Services; if the patient lives in or was transferred from an OPWDD operated/licensed/approved residence.
- Commissioner of OPWDD (or designee-DDSO Director) if Patient does not live in or was not transferred from an OPWDD licensed/operated/approved residence.
- Attending Physician shall record the suspension in the patient's chart