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

Certification on Need 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 10 – Attending Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

This is defined as the proposed treatment is of an urgent need that is expected to be performed within 10 days.

☐ YES ☑ NO

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

Part 2. Patient Information

Last Name: Jones	First Name: Arthur
Agency where the Patient Resides or Receives Services: (Please avoid abbreviations) OPWDD Capital District DDSO	

Phone: Include area code (518) 555-0748	Ext: 518	Fax: Include area code (518) 555-4458

Part 3. Physician/Dentist/Podiatrist

Last Name: Bird	First Name: Adam
Professional License Number: 125488	
Business Address: Hometown Medical Clinic, 200 Main St	

City: Troy		State: NY	Zip: 12180
Phone: Include area code (518) 555-4842	Ext: 478	Fax: Include area code (518) 555-8454	Cell: Include area code (518) 555-5015

Part 4. Findings

Date of Review or Examination of Patient: Date: 07 / 11 / 2017 (MM / DD / YEAR)

I request informed consent for the following medical treatment(s):

Colonoscopy with possible biopsy and /or polypectomy

Patient Last Name: Jones

For SDMC Use Only:

Part 5. Biopsy

Do you anticipate performing a biopsy? ☑ **YES** **Type:** possible polypectomy ☐ **NO** ☐ **UNKNOWN**

If yes, please indicate type.

Part 6. Request

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

History of precancerous polyps
Family history of colon cancer
Five year follow up as recommended after 2012 colonoscopy

b. The following diagnostic tests/examinations have been performed to confirm my recommendation(s). Please include copies of reports.

Previous colonoscopy- see attached report.

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

Inability to complete exam, bleeding, reaction to medication, perforation

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

The benefit would be to remove precancerous lesions and polyps at the earliest possible time, and to diagnose colon cancer at the earliest time.

Part 7. Anesthesia

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)

Part 8. Alternatives

Is there an alternate procedure that is less invasive available to this patient? ☐ **YES** ☑ **NO**

If YES, please state the procedure.

Patient Last Name: Jones

For SDMC Use Only:

Please explain the rejection of this alternative procedure.

Part 9. Risks

What are the risks of non-treatment?

Without a colonoscopy we would risk missing a timely diagnosis of colon cancer.

Part 10. Attestation

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

Signature of Physician/Dentist/Podiatrist: *Adam Bird, MD*

Date: 07 / 14 / 2017

MM DD YEAR

Part 11. Co-signer Attestation

If the evaluation has been performed by OTHER than a licensed physician, dentist or podiatrist, this form must be CO-SIGNED below.

Print Last Name:	Print First Name:
Check all that apply: ☐ Licensed Physician ☐ Licensed Dentist ☐ Licensed Podiatrist	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 Licensed Physician/Dentist/Podiatrist:

Date: / /

MM DD YEAR