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: Jones | First Name: Arthur

Part 2. Current Medications

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

Current medication	Dosage	Frequency	Mode of Intake
KCL (Potassium Chloride)	20 MEQs	qd	via g-tube
Zyprexa	5 mg	qd	via g-tube
Lasix	20 mg	qd	via g-tube
Prostava	30ml	bid	via g-tube
Albuterol	2.5 mg/3ml	q 6 hours prn wheezing	nebulizer
Levothyroxine	125 mcg tab	qd	via g-tube
Ferrous Sulfate	220/5ml	qd	via g-tube

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

Levothyroxine

Part 3. Allergies

Any known allergies?

NKDA

Patient Last Name: Jones

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: 01/16/2017

b. List any abnormal findings from exams and tests:

☐ **N/A**

Hx C-Diff, hx of recurrent UTI, Esotropia (R eye), chronic constipation, chronic anemia,mild scoliosis, hemorrhoids, dyslipidemia, hypothyroidism, CHF, osteoporosis, history of precancerous polyps

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: 07/11/2017

Part 5. Additional Information

a. List any cardiac or pulmonary condition(s):

☐ **N/A**

HTN, CHF, COPD

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

☐ **N/A**

10 day hosp. for respiratory failure and pneumonia (ventilator x5 days) 3 months ago

c. List any other known physical conditions or medical diagnoses:

☐ **N/A**

Please see 4b

Part 6. Anesthesia

Has the patient had general anesthesia before?
(Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.)

☐ Yes ☐ No ☑ Unknown

Patient Last Name: Jones

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: Bill		Print First Name: Patricia	
Email Address: patricia.bill@sunmount.ny			
Agency Name: (Please avoid abbreviations) Capital District DDSO			
Business Address: 145 State St.			
City: Troy		State: NY	Zip: 12180
Phone: Include area code (518)555-5248	Ext: 548	Fax: Include area code (518)555-7215	Cell: Include area code (518)555-8154

Part 10. Attestation

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

Signature of Form Submitter: *Mary McCall*

Date: 07 / 18 / 2017

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