

MAIL ALL FOUR COMPLETED FORMS TO:

**NYS Justice Center for the Protection
of People with Special Needs
SDMC
161 Delaware Avenue
Delmar, NY 12054**

**INSTRUCTIONS FOR SDMC FORM 210
Certification on Capacity**

If this is your first time preparing a case or you have questions, call 518-549-0328.

Verify the answer includes. . . .

1. . . . the full name of the person completing the examination/interview, their title and New York State license number, if applicable (see #7).
2. . . . the full mailing address and work phone and fax numbers of the person completing the examination/interview.
3. . . . the date the patient was examined/interviewed, the patient's name and mental disability/diagnosis.
4. . . . the results of the most recent psychological tests and or the patient's IQ/mental age, if available.

***NOTE:** The patient does not have to undergo testing in order to complete this form.

5. . . . a summary of the clinical evaluation and patient's reaction that validates the determination that the patient does not have the capacity to provide informed consent for this proposed major medical treatment(s).

***NOTE:** For individuals with a diagnosis of SEVERE TO PROFOUND mental retardation, this form may be completed in advance addressing that the patient lacks the capacity to provide informed consent for any and all major medical treatment. In this case, the form would be accepted as certification of capacity for one year from the date it was completed. The form can be updated for specific proposed major medical treatment(s) as necessary.

6. . . . the full name of the person completing the examination/interview, their signature and date.
7. . . . the Supervising Psychiatrist/Psychologist has listed their title and co-signed the form if the examination/interview was performed by someone other than a NYS Licensed Psychiatrist or Psychologist. Verify the answer includes their clearly printed name, signature, date and NYS license number.