

<p>Mail all <u>five completed</u> forms and <u>supplemental information</u> to:</p> <p>NYS Justice Center for the Protection of People with Special Needs SDMC 401 State Street Schenectady, NY 12305</p>	<p>INSTRUCTIONS FOR SDMC FORM 320-B</p> <p>Concurring Physician Certification</p>	
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If this is your first time preparing a case or you have questions, call 518-549-0328

Verify the answer includes. . . .

- 1a. . . . Yes or No is checked.
- 1b. . . . The medical facts supporting the need for a more immediate decision. This means that the physician feels the decision needs to be made and implemented in the next week to 10 days. If you are aware that this is not the case, please contact the physician and change the answers in 1a and 1b if the doctor agrees, before sending the case to SDMC
2. . . . The full name, title of the Concurring Physician completing the examination and their license number.
3. . . . The complete mailing address and work phone and fax numbers of the Concurring Physician completing the examination.
4. . . . The date the patient was examined, the patient's name and medical condition(s). (One or more **MUST** be checked)
- 5a. . . . Each proposed major medical treatment(s) for which consent to withhold or withdraw treatment is being requested. The response should include the exact wording for the consent.
- 5b. . . . A description of the extraordinary burden the treatment would be or has become to the patient, along with copies of any reports that support that finding.
- 5c. . . . Whether the request is to withhold or withdraw artificial nutrition (a feeding tube) or hydration (IV fluids). Yes or no is checked.
- 5d. . . . If the answer to 7a is yes, that one or both of the criteria are checked.
- 5e. . . . If the extraordinary burden is not the same as that already described in response to 5b, the answer should include a description of the burden to the patient specific to the administration of artificial nutrition and/or hydration, along with copies of any reports that confirm this recommendation.
- 5f. . . . Yes or No is checked. If yes, include the hospice evaluation if any.

6. . . . A description of the expected outcome of providing or continuing the life sustaining treatment, along with copies of any reports that support that finding.
7. . . . The Attending Physician's clinical opinion that supports how withholding or withdrawing of life sustaining treatment as being in the patient's best interest.
- 8a. . . .Yes or no is checked.
- 8b. . . . If yes, the procedure is listed.
- 8c. . . . An explanation of the reason that procedure is being rejected is included.
9. . . . The full **printed** name of person completing this form, their signature and date.