



**Justice Center for the
Protection of People
with Special Needs**

**Certification on Capacity
for End of Life Care**

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460

Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

All Parts of this form must be completed. Type or print in black ink.

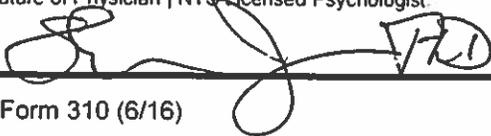
Part 2 & 3 – An attending Physician, in consultation with another Physician or NYS Licensed Psychologist must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Patient Information			
Last Name: Case		First Name: Michael	
Part 2. Attending Physician			
Last Name: Shepherd		First Name: Casey	
Email Address:		Professional License Number:	
Business Address: 1 Apple Tree Lane			
City: West Adirondack		State: NY	Zip: 14001
Phone: <small>Include area code (</small> 518 <small>)</small> 555-5709	Ext:	Cell: <small>Include area code (</small> <small>)</small>	Fax: <small>Include area code (</small> 518 <small>)</small> 555-5710
a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability: Anoxic brain injury with brain he9/209rniation; Down Syndrome, Intellectual disability with significant adaptive deficits			
b. The extent and probable duration of this intellectual disability or incapacity is: Lifelong, since birth			
c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.) no tests are available at this time			
d. Summarize the 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. Michael did not noticeably respond. He is verbally unresponsive at this time.			
I am an attending physician for the patient and the information and statements which I have provided are to the best of my knowledge, complete and truthful.			
Signature of Attending Physician: Casey Shepherd MD		Date: 09/22/2016	

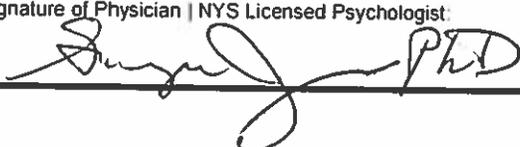
Patient Last Name: Case

For SDMC Use Only:

Part 3. Consulting Physician or NYS Licensed Psychologist			
Last Name: Jung		First Name: Sigmund	
Email Address:		Professional License Number: 001001	
Business Address: 14 Flower St.			
City: Newton		State: NY	Zip: 10121
Phone: (518) 555-4170	Ext:	Cell: ()	Fax: (518) 555-4171
Check all that apply: <input type="checkbox"/> Consulting Physician <input checked="" type="checkbox"/> NYS Licensed Psychologist		Date of Examination of Patient: 09/22/2016	
a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability: Down Syndrome and Profound ID. Pt is currently unresponsive.			
b. The extent and probable duration of this intellectual disability or incapacity is: Permanent and irreversible			
c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.) NA			
d. Summarize the 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. Mr. Case is unresponsive- he blinks his eyes intermittently. He does not have the capacity to make end of life decisions.			
It is my clinical opinion that the patient <u>does not have</u> the capacity to make an informed decision regarding the proposed withholding/withdrawal of life sustaining treatment(s). The information and statements which I have provided are to the best of my knowledge, complete and truthful.			
Signature of Physician NYS Licensed Psychologist:		Date:	
		09/22/2016	

Patient Last Name: Case

For SDMC Use Only:

Part 4. Attestation	
A request for a decision to withdraw or withhold life sustaining treatment requires one of the above providers; attending physician, consulting physician or NYS licensed psychologist to meet one of the following criteria:	
Print Last Name: Jung	Print First Name: Sigmund
Check all that apply	
<input type="checkbox"/> Employed by a Developmental Disability Services Office as defined in Mental Hygiene Law § 13.17	
<input type="checkbox"/> Has been employed for a minimum of two years to render care and services in a Program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD).	
<input checked="" type="checkbox"/> Has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD)	
Signature of Physician NYS Licensed Psychologist: 	Date: 09/22/2016