



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

**Supplemental Medical Information  
for End of Life Care**

**SDMC**

**401 State Street**

**Schenectady, NY 12305**

**Fax: 518-549-0460**

**Email: [SDMC@justicecenter.ny.gov](mailto:SDMC@justicecenter.ny.gov)**

**INSTRUCTIONS:**

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

Part 8 – The person submitting the form must complete, sign and date where indicated.

Please attach: consults, progress notes, annual physical exam, results of diagnostic tests and other related documentation.

**For SDMC Use Only:**

**Part 1. Patient Information**

Last Name:

First Name:

**Part 2. Current Medications**

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

Current medication	Dosage	Frequency	Mode of Intake

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

**Part 3. Allergies**

Please list any known allergies.

Patient Last Name:

For SDMC Use Only:

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Part 4. Exams and Tests	
a. Date of most recent annual physical examination. Include a copy of the most recent physical.	
b. List any abnormal findings from exams and tests:	<input type="checkbox"/> N/A
c. Date of most recent EKG. Include a copy.	<input type="checkbox"/> N/A
d. Date of most recent chest x-ray. Include a copy.	<input type="checkbox"/> N/A
e. Date of most recent laboratory tests. Include a copy of the most recent lab work.	

Part 5. Additional Information	
a. List any cardiac or pulmonary condition(s):	<input type="checkbox"/> N/A
b. List any major illness, surgery, and/or hospitalizations in the last year:	<input type="checkbox"/> N/A
c. List any other known physical condition or medical diagnosis:	

Part 6. Prior SDMC Review	
a. Has the patient been reviewed by SDMC previously?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
b. Date that the most recent SDMC approved procedure was performed:	
c. Procedure(s) previously requested:	
d. Results of procedure(s):	

Patient Last Name: Case

For SDMC Use Only:

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<b>Part 7. Form Submitter's Contact Information</b>			
Last Name: <b>Moore</b>		First Name: <b>Bessie</b>	
Business Email Address: <b>bessie.moore@opwdd.ny.gov</b>		Title: <b>RN</b>	
Agency Name: <b>Sunmount DDSO</b> <small>(Please avoid abbreviations)</small>			
Business Address: <b>4 Keystone Lane</b>			
City: <b>Adirondack</b>		State: <b>NY</b>	Zip: <b>14321</b>
Phone: <small>Include area code</small> ( <b>518</b> ) <b>555-2132</b>	Ext:	Cell <small>Include area code</small> ( <b>518</b> ) <b>555-2133</b>	Fax <small>Include area code</small> ( <b>518</b> ) <b>555-2133</b>
<b>Part 8. Attestation</b>			
The above information and statements are given to the best of my knowledge, complete and truthful.			
Signature of Form Submitter: <i>Bessie Moore, RN</i>		Date: <b>09/22/2016</b>	

**PLEASE REMEMBER TO ATTACH**

Documentation related to the requested End of Life Care:

- Consults
- Annual Physical Exam
- Progress notes
- Results of diagnostic tests