

**SURROGATE DECISION-MAKING COMMITTEE  
PROCEEDING FOR THE REVIEW OF THE NEED FOR  
SURROGATE DECISION-MAKING ON BEHALF OF**

**DECLARATION FOR  
SURROGATE  
DECISION-MAKING**

\_\_\_\_\_  
(Patient's Name)

\_\_\_\_\_  
Declaration # (SDMC Use Only)

**ALL QUESTIONS MUST BE ANSWERED TO PREVENT A DELAY IN PROCESSING THE CASE**

To the Surrogate Decision-Making Committee:

1a. I am the Declarant for the above named individual; my name, work address and telephone numbers are:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agency/Organization Name: \_\_\_\_\_

Full Mailing Address: \_\_\_\_\_

**(We will contact you regarding this declaration. Please list contact information where you can be reached Monday through Friday, during regular business hours.)**

Work Phone (\_\_\_\_\_) \_\_\_\_\_ EXT. \_\_\_\_\_

Work FAX (\_\_\_\_\_) \_\_\_\_\_

Beeper (\_\_\_\_\_) \_\_\_\_\_

Work Cell (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

1b. My relationship with the patient is (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Direct Care Staff  | <input type="checkbox"/> Family Care Provider         | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Social Worker      | <input type="checkbox"/> Service Coordinator          | <input type="checkbox"/> Physician Assistant       |
| <input type="checkbox"/> Case Manager       | <input type="checkbox"/> Nurse                        | <input type="checkbox"/> Residence Manager         |
| <input type="checkbox"/> Executive Director | <input type="checkbox"/> Physician/Dentist/Podiatrist | <input type="checkbox"/> Other: _____              |

2. Does the patient receive services from any outside OPWDD, OMH, or OASAS organization/agency?

Yes  No

If yes, list organization/agency names: \_\_\_\_\_

3. Who explained the proposed major medical treatment(s) to the patient?

(Title Only) \_\_\_\_\_

4. Describe the patient's reaction when the proposed major medical treatment(s) was/were explained, and any opinions expressed: \_\_\_\_\_

\_\_\_\_\_

**\*\*DO NOT STAPLE FORMS\*\***

5a. Are there any known Legally Authorized Surrogates as specifically identified in Article 80 of the Mental Hygiene Law?  Yes  No If yes, check all that apply.  Parent  Spouse  Adult Child  Guardian/Conservator/Committee of the Person  Health Care Proxy

5b. Indicate the status of the patient's mother.  Living  Deceased  Whereabouts Unknown  
Indicate the status of the patient's father.  Living  Deceased  Whereabouts Unknown

5c. Provide the following information for **anyone living listed above**. **Explain all of your answers.**

<p>Name: _____ Address: _____ _____ Phone: ( _____ ) Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: ( _____ ) Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: ( _____ ) Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: ( _____ ) Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>

**\*\*DO NOT STAPLE FORMS\*\***

6a. Are there any known actively involved adult siblings, or other family members, who are unavailable, do not wish to make the decision or are not authorized to make the decision?  
 Yes       No      If yes, list below.

6b. Are there any correspondents, community advocates or a FAMILY CARE PROVIDER?  
 Yes       No      If yes, list below.

6c. For current or former OPWDD patients **ONLY**: If the patient has one or more actively involved sibling or other adult family member explain why surrogate decision-making is needed (e.g.: family members are unavailable, family members do not wish to make the decision and/or they want SDMC to resolve a possible objection or difference of opinion). **Explain all of your answers.**

Name: _____ Address: _____ _____ Phone: ( _____ ) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____	Name: _____ Address: _____ _____ Phone: ( _____ ) _____ Relationship: _____ <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion <input type="checkbox"/> Other <input type="checkbox"/> Does Not Wish to Make Decision How contacted? <input type="checkbox"/> Phone <input type="checkbox"/> mail <input type="checkbox"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____
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7. For persons listed in sections 5 and 6 who were not able to be contacted, please list what efforts were made to contact them to discuss this case.

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8. As the Declarant, I have read SDMC Form 210 (Certification on Capacity) that has been completed by \_\_\_\_\_ and **signed on** \_\_\_\_\_  
(Name of Psychiatrist or Psychologist) (Date)  
indicating his/her professional opinion that the patient does not have the capacity to provide informed consent for the proposed major medical treatment(s).

9. The proposed major medical treatment(s) is/are as follows (per SDMC Form 220-A, #4a and 4b):

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10. Is the use of general anesthesia anticipated? \_\_\_ Yes \_\_\_ No (per SDMC Form 220-A, #7)

11. Is an HIV test being requested? \_\_\_ Yes \_\_\_ No (per SDMC Form 220-A, #5)

12. As the Declarant, I have read SDMC Form 220-A (Certification of Need for Major Medical Treatment) that has been completed by \_\_\_\_\_  
(Name of Physician/ Dentist/Podiatrist)  
and **signed on** \_\_\_\_\_ describing the patient's medical/dental condition, the proposed  
(Date)  
major medical treatment(s), the risks, benefits and alternative(s) to the proposed procedure.

13. In my opinion, the patient cannot give informed consent for this procedure because:

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14. In my opinion, the proposed major medical treatment(s) is/are in the best interest of the patient because:

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15. This declaration is made on behalf of:

a. Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

(Phone Number of Patient's Residence)

c. Type of Residence: \_\_\_\_\_ ICF \_\_\_\_\_ CR

\_\_\_\_\_ DC \_\_\_\_\_ FC \_\_\_\_\_ IRA \_\_\_\_\_ CW

\_\_\_\_\_ PC \_\_\_\_\_ Hospital Psychiatric Ward

\_\_\_\_\_ Nursing Home \_\_\_\_\_ Adult Home

\_\_\_\_\_ Assisted Living \_\_\_\_\_ Waiver Services

\_\_\_\_\_ OMH funded or approved housing

\_\_\_\_\_ Other: \_\_\_\_\_

b. Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Month Day Year)

Age: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Religion: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Does the patient have special communication needs?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, what type: \_\_\_\_\_ foreign language

\_\_\_\_\_ communication board or other assistive device

\_\_\_\_\_ sign language interpreter \_\_\_\_\_ other

d. County of Residence: \_\_\_\_\_

16. Name of Second Contact: \_\_\_\_\_ Title: \_\_\_\_\_

**(An alternate contact to Declarant must be provided.)**

Second Contact's Full Mailing Address (Organization Name): \_\_\_\_\_

\_\_\_\_\_

Street

City

State

Zip

Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ EXT. \_\_\_\_\_

FAX Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Beeper ( \_\_\_\_\_ ) \_\_\_\_\_

Work Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Email \_\_\_\_\_

17. To the best of my knowledge, the above information and statements are truthful and complete.

\_\_\_\_\_  
Print Declarant's Name Clearly

\_\_\_\_\_  
Declarant's Signature

\_\_\_\_\_  
Date

**NOTE: This form must be dated the same or later than the other SDMC Forms in the case.**