

<p>Mail all <u>four completed forms and 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>SDMC FORM 200</p> <p>Declaration for Surrogate Decision-Making</p>	
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If this is your first time preparing a case or if you have questions, call SDMC at 518-549-0328
Do not double side case information, including forms. Do not staple pages together.

**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

1. 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: _____

List contact information where you can be reached Monday through Friday, during regular business hours.

Work Phone (_____) _____ Ext. _____ Work FAX (_____) _____
Work Cell (_____) _____ Email _____

2. Other than the agency you work for, list the primary contact person for all other OPWDD, OMH, or OASAS-funded or licensed/regulating organizations/agencies providing services to the patient (MSC, Nurse, Residential, etc.). **If the patient is hospitalized**, but the declarant is not a member of hospital staff, list the hospital contact information. **All persons listed below will receive notice of the hearing.**

<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ Comments:</p>	<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ Comments:</p>
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3. Day Program Provider – List Agency: _____

4. List **Title** of person who explained the proposed major medical treatment(s) to the patient

Describe the patient's reaction when the treatment(s) was/were explained, and any opinions expressed:

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 why they are not available to participate in the decision making process.**

Name: _____ Address: _____ _____ Phone: (____) _____ Email: _____ 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"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments:	Name: _____ Address: _____ _____ Phone: (____) _____ Email: _____ 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"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments:
Name: _____ Address: _____ _____ Phone: (____) _____ Email: _____ 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"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments:	Name: _____ Address: _____ _____ Phone: (____) _____ Email: _____ 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"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Unable to contact (see #7) Comments:

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(s) or other adult family member(s) explain why surrogate decision-making is needed (e.g.: family members are unavailable, do not wish to make the decision and/or they want SDMC to resolve a possible objection or difference of opinion). **Explain your answers.**

<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ _____ Agree _____ Disagree _____ No Opinion _____ Other _____ Does Not Wish to Make Decision How contacted? _____ Phone _____ Mail _____ Email _____ In Person _____ Unable to contact (see #7) Comments:</p>	<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ _____ Agree _____ Disagree _____ No Opinion _____ Other _____ Does Not Wish to Make Decision How contacted? _____ Phone _____ Mail _____ Email _____ In Person _____ Unable to contact (see #7) Comments:</p>
<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ _____ Agree _____ Disagree _____ No Opinion _____ Other _____ Does Not Wish to Make Decision How contacted? _____ Phone _____ Mail _____ Email _____ In Person _____ Unable to contact (see #7) Comments:</p>	<p>Name: _____ Agency: _____ Address: _____ _____ Phone: (_____) _____ Email: _____ Relationship: _____ _____ Agree _____ Disagree _____ No Opinion _____ Other _____ Does Not Wish to Make Decision How contacted? _____ Phone _____ Mail _____ Email _____ In Person _____ Unable to contact (see #7) Comments:</p>

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.

8. As the Declarant, I have read SDMC Form 210 (Certification on Capacity) that has been completed by _____ and signed on _____
(Name of NYS Licensed Psychiatrist/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):

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

_____ and signed on _____
(Name of Physician/ Dentist/Podiatrist) (Date)

describing the patient's medical/dental condition, the proposed major medical treatment(s), the risks, benefits and alternative(s) to the proposed procedure.

13. Based on **your personal knowledge** of this patient, **explain in your own words** why the patient cannot give informed consent for this procedure

14. Based on **your personal knowledge** of this patient, **explain in your own words** why you believe the proposed treatment(s) is/are in the best interest of the patient.

