

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

**CERTIFICATION
ON CAPACITY**

(Patient's Name)

Declaration # (SDMC Use Only)

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

1. I, _____, am a _____,
(Clinician's Name) (Psychiatrist or Psychologist)
duly licensed to practice in the State of New York and my professional New York State License Number
is _____.

2. My office address and phone number are:

(Street) (City) (State) (Zip)
Phone: () Fax: ()

3. On _____, I examined/interviewed _____.
(Date) (Patient's Name)

As a result of this examination/interview, I have diagnosed that he/she has the following mental disability:

Diagnosis: _____

4. If available, list any recent psychological tests results and/or the patient's IQ/Mental Age.
(NOTE: testing is not necessary to complete this form.)

- 5. Summarize your clinical evaluation, including the patient's reaction when you explained the proposed major medical treatment(s) and its risks and benefits that validate your opinion regarding the patient's decision-making ability.

It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding this major medical procedure/treatment.

- 6. The information and statements which I have provided are to the best of my knowledge complete and truthful.

_____	_____
Print Name Clearly	Signature

	Date

If the evaluation has been performed by other than a New York State Licensed Psychiatrist or Psychologist, this form must be CO-SIGNED below.

- 7. I am a NYS licensed _____. I concur with the above clinical evaluation and certify that it is complete and truthful to the best of my knowledge.

_____	_____
Print Name Clearly	Signature

NYS License Number	Date