

Mail all four completed forms and supplemental information to:

NYS Justice Center for the Protection of  
People with Special Needs  
SDMC  
401 State Street  
Schenectady, NY 12305

SDMC FORM 220-A  
**Certification on Need  
for Major  
Medical Treatment**



**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**

**CERTIFICATION ON NEED  
FOR MAJOR MEDICAL  
TREATMENT**

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

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

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

1a. Is an Expedited Review necessary? \_\_\_\_ Yes \_\_\_\_ No

1b. If an expedited case review is being requested, state the medical facts indicating its need. An expedited case review is where the patient's treatment needs are urgent but not an emergency.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. I, \_\_\_\_\_, am a \_\_\_\_\_  
(Name) (Physician, Dentist or Podiatrist/Field of Medicine)

and my professional license number is \_\_\_\_\_.

3. My office address and phone number are:

\_\_\_\_\_  
(Street) (City) (State) (Zip)

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

4a. On \_\_\_\_\_ I examined/reviewed \_\_\_\_\_  
(Date) (Patient's Name)

As a result of my examination and review of the medical record, I request informed consent for the following major medical treatment(s):

\_\_\_\_\_  
\_\_\_\_\_

4b. Do you anticipate performing a biopsy? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown

Note type: \_\_\_\_\_

**It is my clinical opinion that this proposed major medical treatment(s) is/are in the best interest of this patient.**

5. Do you anticipate performing an HIV test? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Public Health Law section 2781 (3)** requires that the person ordering the HIV test must provide counseling and information regarding HIV testing risks and benefits to the patient to the extent possible.

These include:

- (a) HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants;
- (b) there is treatment for HIV that can help an individual stay healthy;
- (c) individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV;
- (d) testing is voluntary and can be done anonymously at a public testing center;
- (e) the law protects the confidentiality of HIV related test results;
- (f) the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and
- (g) the law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

6. Is the use of general anesthesia anticipated? \_\_\_\_\_ Yes \_\_\_\_\_ No

***Only answer YES if the patient will be unconscious and intubated during the treatment.***

When the treatment plan does not include general anesthesia, if on the day of the proposed major medical treatment(s) the use of general anesthesia becomes necessary, Public Health Law Section 2805-d provides for the disclosure of reasonably foreseeable risks. Common/severe complications of general anesthesia include: hoarseness, nausea, sore throat, broken teeth, tracheal or esophageal injuries, respiratory distress, cardiac failure and death.

(Source: American Society of Anesthesiologists)

7a. Clinical indications for the requested proposed major medical treatment(s):

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7b. In my clinical opinion the **risks** specific to this proposed major medical treatment(s) is/are:

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7c. In my clinical opinion the **benefits** specific to this proposed major medical treatment(s) is/are:

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8. The following diagnostic tests/examinations have been performed to confirm my recommendation(s):  
(Include copies of reports.)

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9. Is there an alternative less-invasive procedure available to this patient? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, state procedure: \_\_\_\_\_

Explain your rejection of this alternative procedure below: \_\_\_\_\_

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10. Explain the **risk of non-treatment**: \_\_\_\_\_

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11. The above information and statements are to the best of my knowledge truthful and complete.

\_\_\_\_\_  
**Print Name Clearly**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

*If the evaluation has been performed by other than a licensed physician, dentist or podiatrist,  
this form must be co-signed below.*

12. I am a licensed \_\_\_\_\_. I concur with the above clinical evaluation  
(Physician/Dentist/Podiatrist)  
and certify that it is complete and truthful to the best of my knowledge.

\_\_\_\_\_  
**Print Name Clearly**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**License #**

\_\_\_\_\_  
**Date**