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

**SUPPLEMENTAL MEDICAL  
INFORMATION**

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(Patient's Name)

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Declaration # (SDMC Use Only)

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

1a. Current medications, dosages, frequency and mode of intake:

_____	_____
_____	_____
_____	_____
_____	_____

1b. List any drugs requiring frequent blood level monitoring. (Include copy)

_____	_____
_____	_____

2. Any known allergies: \_\_\_\_\_  
\_\_\_\_\_

3. Annual physical examination: \_\_\_\_\_ (Must include copy)  
(Date)  
Abnormal findings: \_\_\_\_\_  
\_\_\_\_\_

4. Most recent EKG: \_\_\_\_\_ (Include copy, if available)  
(Date)

5. Most recent Chest X-ray: \_\_\_\_\_ (Include copy, if available)  
(Date)

6. Most recent laboratory tests: \_\_\_\_\_ (Include copy, if available)  
(Date)

7. Has there been a second opinion? If so what type? \_\_\_\_\_ Capacity \_\_\_\_\_ Best Interest

8. List any cardiac or pulmonary condition(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. List any major illness, surgery and/or hospitalizations in the last year:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. List any other known physical conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Has this patient had general anesthesia before?    \_\_\_\_ Yes    \_\_\_\_ No    \_\_\_\_ Unknown  
Date of most recent general anesthesia: \_\_\_\_\_  
Any history of adverse reactions to general anesthesia? \_\_\_\_ Yes    \_\_\_\_ No    \_\_\_\_ Unknown

*\*IV sedation and MAC are not considered general anesthesia for SDMC cases.*

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. MHL Article 80 requires the patient to be present at the hearing. Is there any medical condition that would prevent the patient from attending the hearing?    \_\_\_\_ Yes    \_\_\_\_ No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

13. Is the requested procedure(s) scheduled?  Yes  No  
If yes, date: \_\_\_\_\_ If no, when is the anticipated scheduled date? \_\_\_\_\_

14. Has the patient been reviewed by SDMC previously?  Yes  No  Unknown  
If yes, answer the following (if known):

a. Date most recent SDMC approved procedure performed: \_\_\_\_\_

b. Procedure(s) previously requested: \_\_\_\_\_

c. Results of procedure(s): \_\_\_\_\_

15. If the patient has been transferred to a healthcare facility other than their residence, please provide the following information:

Facility Name: \_\_\_\_\_

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

Facility Contact Person: Name: \_\_\_\_\_

Contact's Phone #: ( ) \_\_\_\_\_ Patient's Room #: \_\_\_\_\_

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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

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

Work Fax: ( ) \_\_\_\_\_

**PLEASE REMEMBER TO ATTACH:**

Consults, progress notes, annual physical exam, results of diagnostic tests and other documentation related to the proposed major medical treatment(s) being requested.