

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-B
**Supplemental Medical
Information**



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**

**SUPPLEMENTAL MEDICAL
INFORMATION**

(Patient's Name)

Declaration # (SDMC Use Only)

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: _____ (Always include copies)

(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 a **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 and Agency Name

Date

Work Phone: (_____) _____

Work Cell: (_____) _____

Work Fax: (_____) _____

Email: _____

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.