

**SURROGATE DECISION-MAKING COMMITTEE
PROCEEDING FOR THE REVIEW OF APPROPRIATENESS
OF WITHDRAWAL OR WITHHOLDING OF LIFE
SUSTAINING TREATMENT**

**DECLARATION FOR
HEALTH CARE
DECISIONS ACT**

(Patient's Name)

Declaration # (SDMC Use Only)

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

To the Surrogate Decision-Making Committee:

1a. I am the Declarant for the above named individual; my name, work address and telephone numbers are:

Name: _____ Title: _____

Organization Name: _____

Full Mailing Address: _____

(We will contact you regarding this declaration. Please list contact information where you can be reached.)

Work Phone (_____) _____ EXT. _____

Work FAX (_____) _____

Beeper (_____) _____

Work Cell (_____) _____

Email _____

1b. My relationship with the patient is (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Direct Care Staff | <input type="checkbox"/> Family Care Provider | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Service Coordinator | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse | <input type="checkbox"/> Residence Manager |
| <input type="checkbox"/> Executive Director | <input type="checkbox"/> Physician/Dentist | <input type="checkbox"/> Other: |

2. Does the patient receive services from any outside OPWDD, OMH, or OASAS organization/agency?
 Yes No

If yes, list organization/agency names: _____

3. Who explained the proposed withholding/withdrawal of life sustaining treatment(s) to the patient? _____(Title Only)

4. Describe the efforts to determine the moral and religious beliefs of the patient, and the patient's reaction when the proposed withholding/withdrawal of life sustaining treatment(s) was/were explained.

5a. Are there any known Legally Authorized Surrogates specifically identified by 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 all of your answers.**

<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>

****DO NOT STAPLE FORMS****

6a. Are there any known actively involved adult siblings, or other family members, who do not wish 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. If physician checked Yes to HOSPICE (Ques. #6 on SDMC Form 320-A), include contact information for HOSPICE Coordinator below.

6d. If the patient has one or more actively involved siblings or other adult family members, explain why surrogate decision-making is needed (e.g.: family members are unavailable, family members 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: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>
<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> Unable to contact (see #7) Comments: _____ _____ _____ _____</p>	<p>Name: _____ Address: _____ _____ Phone: (_____) _____ 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"/> in person <input type="checkbox"/> 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 310 (Certification on Capacity) completed by _____ and signed on _____
(Attending Physician) (Date)

and _____ and signed on _____
(Consulting Physician or Licensed Psychologist) (Date)

indicating his/her professional opinions that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s).

9. The proposed withholding/withdrawal of life sustaining treatment(s) is/are as follows (per #5a on SDMC Forms 320-A and 320-B):

10. Is hospice admission anticipated? _____Yes _____No (Per #6 on SDMC 320-A and 320-B)

11. As the Declarants, I have read SDMC Forms 320-A and 320-B (Attending Physician Certification and Concurring Physician Certification) completed by

_____ signed on _____
(Name of Attending Physician) (Date)

_____ signed on _____
(Name of Concurring Physician) (Date)

describing the patient's medical condition, the risks, benefits and alternative(s) to this/these withholding/withdrawal of life sustaining treatment(s).

12. In my opinion, the patient cannot give informed consent for this/these decision(s) because:

13. It is my opinion that the proposed decision(s) is/are in the best interest of the patient because:

14. This declaration is made on behalf of:

a. Patient's Name: _____
Address: _____

Phone: (_____)
(Phone Number of Patient's Residence)

b. Date of Birth: _____ / _____ / _____
(Month Day Year)
Age: _____
Sex: _____ Male _____ Female
Religion: _____
Primary Language: _____
Does the patient have special communication needs? _____ Yes _____ No
If Yes, what type: _____ foreign language
_____ communication board or other assistive device
_____ sign language interpreter _____ other

c. Type of Residence: _____ ICF _____ CR
_____ DC _____ FC _____ IRA _____ CW
_____ PC _____ Hospital Psychiatric Ward
_____ Nursing Home _____ Adult Home
_____ Assisted Living _____ Waiver Services
_____ OMH funded or approved housing
_____ Other: _____

d. County of Residence: _____

15. Name of Second Contact: _____ Title: _____
(An alternate contact to Declarant must be provided.)

Second Contact's Full Mailing Address (Organization Name): _____

Street City State Zip

Work Phone (_____) EXT. _____
FAX Phone (_____)
Beeper (_____)
Work Cell (_____)
Email _____

16. This request is based on the patient's qualifying medical condition other than mental retardation or developmental disability, with recognition that a person with mental retardation or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without mental retardation or developmental disabilities and without any financial considerations that affect the health care provider or any other party. To the best of my knowledge, the above information and statements are truthful and complete.

Print Declarant's Name Clearly

Declarant's Signature

Date

NOTE: This form must be dated the same or later than the other SDMC Forms in the case.