

Mail all five 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 310
**Certification
On Capacity**



Do not double side case information, including forms. Do not staple pages together.

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

A. STATEMENT OF ATTENDING PHYSICIAN

1. I, _____, am an attending physician for the patient,
(Print Physician's Name)

_____, and my professional License Number is _____.
(Print Patient's Name)

2. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

3. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The cause and nature of the patient's intellectual disability/incapacity (**Diagnosis**) is:

The extent and probable duration of this intellectual disability/incapacity is:

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

Signature of Attending Physician

Date

B. STATEMENT BY CONSULTING PHYSICIAN OR PSYCHOLOGIST

5. I, _____ am a _____
(Print Name) (Consulting Physician or NYS Licensed Psychologist)
and my professional license number is _____.

6. My office address and phone number are:

(Street) (City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

7. On _____, I examined/interviewed _____.
Date Patient's Name

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

(Diagnosis – Cause and Nature of Incapacity)

8. The extent and probable duration of this intellectual disability/incapacity is:

9. 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.)

10. Summarize your clinical evaluation, including the patient's reaction, when you explained the proposed withholding/withdrawal of life sustaining treatment(s) that validates 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 the proposed withholding/withdrawal of life sustaining treatment(s).

11. The information and statement which I have provided are to the best of my knowledge complete and truthful.

Signature Consulting Physician/NYS Licensed Psychologist

_____ Date

**TO BE COMPLETED BY THE
ATTENDING PHYSICIAN OR CONSULTANT**

12. A request for a decision to withdraw or withhold life-sustaining treatment requires one of the above attending or consulting physicians or NYS licensed psychologists to meet one of the following criteria

_____ is either (select at least one)
Print Name Physician/NYS Licensed Psychologist

- employed by a developmental disabilities services office MHL § 13.17
- has been employed for a minimum of two years to render care and service in a program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD)
- has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD).

Signature Physician/NYS Licensed Psychologist

Date