

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

**CONCURRING PHYSICIAN
CERTIFICATION**

Declaration # (SDMC Use Only)

(Patient's Name)

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 needs are urgent but not an emergency.

- 2. I, _____, am a physician for the patient, and my
(Print Name)
professional license number is _____.

- 3. My office address and phone number are: _____
(Street) (City) (State) (Zip)

Phone: () _____ Fax: () _____

- 4. On _____ I **personally** examined _____
(Date) (Patient's Name)

As a result of such examination, I diagnosed to a reasonable degree of medical certainty that the patient lacks capacity, has mental retardation or developmental disability and suffers from the following medical condition/s (**must check one or all that apply**):

- a terminal condition in that the patient has an illness or injury from which there is no recovery and which reasonably can be expected to cause death within one year; or,
- permanent unconsciousness; or
- a medical condition other than mental retardation or developmental disability which requires life-sustaining treatment, is irreversible and which will continue indefinitely.

5a. Based on the medical diagnosis, I request consent to withhold/withdraw the following life-sustaining treatment(s) (write exact wording you want on the consent form):

Circle One

I find further that the life-sustaining treatment would impose an extraordinary burden on the patient **in light of the person's medical condition** other than the person's mental retardation or developmental disability.

5b. Describe the extraordinary burden of life sustaining treatment(s) for the patient and, if available, list any tests or supporting information that confirms your findings (Include copies of reports.):

5c. Describe the expected outcome of life-sustaining treatment(s) for the patient and, if available, list any tests or supportive information that confirms your findings (Include copies of reports.):

6. Do you anticipate hospice admission? _____ Yes _____ No

7a. Is this a request to withhold or withdraw life-sustaining artificially provided nutrition or hydration for the patient? _____ Yes _____ No **(If no, proceed to Question 8.)**

7b. If yes, I find to a reasonable degree of medical certainty that:

- there is no reasonable hope of maintaining life; or
- the artificially provided nutrition or hydration impose an extraordinary burden on the patient.

7c. If not the same as 5b above, describe the extraordinary burden of providing artificial nutrition and hydration and, if available, any diagnostic tests/examinations that have been performed to confirm my recommendations(s). (Include copies of reports.)

8. In my clinical opinion the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

9a. Is there an alternative procedure available to this patient that will preserve, improve, or restore the person's health? _____ Yes _____ No

9b. If yes, please state procedure: _____

9c. Please explain your rejection of this optional choice.

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

Print Name Clearly

Signature

Date

Please check to see that you have answered all questions.