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

**SUPPLEMENTAL MEDICAL  
INFORMATION**

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Declaration # (SDMC Use Only)

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(Patient's Name)

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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. Most recent physical examination: \_\_\_\_\_ (Must include copy)  
(Date)

Abnormal findings: \_\_\_\_\_  
\_\_\_\_\_

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

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

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

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

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

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

10. 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 #: \_\_\_\_\_

11. 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): \_\_\_\_\_  
\_\_\_\_\_

12. The patient will be visited at least by one panel member.  
Please explain the medical condition that would prevent the patient from attending the hearing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. 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: ( ) \_\_\_\_\_

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) decision.