



Justice Center for the Protection of People with Special Needs

Certification on Capacity for Major Medical Treatment

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460

Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

All Parts of this form must be completed. Type or print in black ink.
Part 3 & 4 - A NYS Licensed Psychologist or Psychiatrist must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Patient Information
Part 2. Clinician
Last Name: First Name:
Last Name: First Name:
Email Address: Professional License Number:
Business Address:
City: State: Zip:
Phone: Ext: Cell: Fax:
Check all that apply:
Licensed Psychiatrist Licensed Psychologist
Date of Examination of Patient | Review of Record:
a. As a result of this examination/review, the patient has been diagnosed with the following intellectual disability or psychiatric diagnosis:
b. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age.
c. Summarize the clinical evaluation, including the patient's reaction, when you explained the proposed major medical treatment(s) and its risks and benefits that validate your opinion regarding the patient's decision making ability.

Patient Last Name:

For SDMC Use Only:

|   |                              |
|---|------------------------------|
| <b>Part 3. Attestation</b>  |                              |
| It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding this major medical procedure/treatment. The information and statements which I have provided are to the best of my knowledge, complete and truthful. |                              |
| Signature of Clinician:   | Date:                        |
| <b>Part 4. Co-signer Attestation</b>  |                              |
| If the evaluation has been performed by other than a New York State Licensed Psychiatrist or Psychologist, this form just be CO-SIGNED below.   |                              |
| Print<br>Last Name:   | Print<br>First Name:         |
| Check all that apply:<br><input type="checkbox"/> NYS Licensed Psychiatrist <input type="checkbox"/> NYS Licensed Psychologist  | Professional License Number: |
| I concur with the above clinical evaluation. The information and statements which I have provided are to the best of my knowledge, complete and truthful.   |                              |
| Signature of Physician/Licensed Psychologist:   | Date:                        |