



Justice Center for the Protection of People with Special Needs

Certification on Need for Major Medical Treatment

SDMC
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Schenectady, NY 12305
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Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

All Parts of this form must be completed. Type or print in black ink.
Part 10 - Attending Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

YES NO

This is defined as the proposed treatment is of an urgent need that is expected to be performed within 10 days.

If YES, please state the medical facts to support the request.

Part 2. Patient Information

Last Name:

First Name:

Part 3. Physician/Dentist/Podiatrist

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:

Include area code ( )

Ext:

Cell:

Include area code ( )

Fax:

Include area code ( )

Part 4. Findings

Date of Review or Examination of Patient:

As a result of my examination or review of the medical record, I request informed consent for the following medical treatment(s):

Patient Last Name:

For SDMC Use Only:

**Part 5. Biopsy**

Do you anticipate performing a biopsy?  YES Type: \_\_\_\_\_  NO  UNKNOWN  
If yes, please indicate type.

**Part 6. Request**

a. Clinical indications for the requested proposed major medical treatment(s):

b. The following diagnostic tests/examinations have been performed to confirm my recommendation(s). Please include copies of reports.

c. In my clinical opinion, the risks specific to this proposed major medical treatment(s) is/are:

d. In my clinical opinion, the benefits specific to this proposed major medical treatment(s) is/are:

**Part 7. HIV**

Do you anticipate performing an HIV test?  YES  NO

Public Health Law section 2781 (3) requires that the person ordering the HIV test must provide counseling and information regarding HIV testing risks and benefits to the patient to the extent possible. These include:

- HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants;
- there is treatment for HIV that can help an individual stay healthy;
- individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV;
- testing is voluntary and can be done anonymously at a public testing center;
- the law protects the confidentiality of HIV related test results;
- the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and
- the law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

Patient Last Name:

For SDMC Use Only:

**Part 8a. Anesthesia**

Is the use of general anesthesia anticipated?

(Only answer YES if the patient will be unconscious and intubated during the treatment.)

YES  NO

When the treatment plan does not include general anesthesia, if on the day of the proposed major medical treatment(s) the use of general anesthesia becomes necessary, Public Health Law Section 2805-d provides for the disclosure of reasonably foreseeable risks. Common/severe complications of general anesthesia include: hoarseness, nausea, sore throat, broken teeth, tracheal or esophageal injuries, respiratory distress, cardiac failure and death. (Source: American Society of Anesthesiologists)

**Part 8b. Anesthesia**

If the requested treatment is dental work will it be performed under a local anesthetic?

YES  NO

**Part 9. Alternatives**

Is there an alternate procedure that is less invasive available to this patient?

If YES, please state the procedure.

YES  NO

Please explain the rejection of this alternative procedure.

Explain the risk of non-treatment:

**Part 10. Attestation**

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

Signature of Physician/Dentist/Podiatrist:

Date:

**Part 11. Co-signer Attestation**

If the evaluation has been performed by OTHER than a licensed physician, dentist or podiatrist, this form must be CO-SIGNED below.

Print

Last Name:

Print

First Name:

Check all that apply:

Licensed Physician  Licensed Dentist  Licensed Podiatrist

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 Licensed Physician/Dentist/Podiatrist:

Date: