



Supplemental Medical Information 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 10 – The person submitting the form must complete, sign and date where indicated.

Please attach: consults, progress notes, annual physical exam, results of diagnostic tests and other documentation related to the proposed major medical treatment(s) being requested.

For SDMC Use Only:

Part 1. Patient Information

Last Name:

First Name:

Part 2. Current Medications

a. Provide information pertaining to the patient's current medications.

Table with 4 columns: Current medication, Dosage, Frequency, Mode of Intake. Multiple empty rows for data entry.

b. List any drugs requiring frequent blood level monitoring. Include a copy of the most recent lab work.

Part 3. Allergies

Any known allergies?

Patient Last Name:

For SDMC Use Only:

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Part 4. Exams and Tests			
a. Date of most recent annual physical examination. Include a copy of the most recent physical. Date: _____			
b. Abnormal findings from all exams and tests:		<input type="checkbox"/>	N/A
c. Date of most recent EKG. Include a copy. Date: _____		<input type="checkbox"/>	N/A
d. Date of most recent chest x-ray. Include a copy. Date: _____		<input type="checkbox"/>	N/A
e. Date of most recent laboratory tests. Include a copy of the most recent lab work. Date: _____			
Part 5. Additional Information			
a. List any cardiac or pulmonary condition(s):		<input type="checkbox"/>	N/A
b. List any major illness, surgery, and/or hospitalizations in the last year:		<input type="checkbox"/>	N/A
c. List any other known physical conditions or medical diagnoses:		<input type="checkbox"/>	N/A
Part 6. Anesthesia			
Has the patient had general anesthesia before? Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date of most recent anesthesia: Date: _____		<input type="checkbox"/>	N/A
Any history of adverse reactions to general anesthesia? If yes, describe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Patient Last Name:

For SDMC Use Only:

Part 7. Schedule

Is the requested procedure(s) scheduled? Yes Date: _____ No

If no, what is the anticipated scheduled date?
 The standard consent period is 60 days from the date of the hearing. Is 60 days sufficient? Yes No

If a longer consent is required, please indicate the time frame requested and the reason for the request.

Consent period being requested:
 90 days 120 days 180 days 365 days

Reason for the request: Medical Scheduling

Part 8. Prior SDMC Review

a. Has the patient been previously reviewed by SDMC? Yes No Unknown

b. Date the most recent SDMC approved procedure was performed:

c. Procedure(s) previously requested:

d. Results of procedure(s):

Part 9. Form Submitter's Contact Information

Print Last Name:	Print First Name:		
Email Address:			
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:	State:	Zip:	
Phone: <small>Include area code ()</small>	Ext:	Cell: <small>Include area code ()</small>	Fax: <small>Include area code ()</small>

Part 10. Attestation

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

Signature of Form Submitter: _____ Date: _____

PLEASE REMEMBER TO ATTACH

Documentation related to the proposed major medical treatment(s) being requested:

- Consults
- Annual Physical Exam
- Progress notes
- Results of diagnostic tests