



Form Checklist for End of Life Care Decisions

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

Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

To avoid delays in case processing, all SDMC forms must be completed and all required supporting documents submitted.

- Do not double side case information, including forms
Do not staple pages together

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Empty box for SDMC use only.

Be sure to include fully completed:

- SDMC Form 300 Declaration for End of Life Care
SDMC Form 310 Certification on Capacity for End of Life Care
SDMC Form 320-A Attending Physician Certification for End of Life Care
SDMC Form 320-B Concurring Physician Certification for End of Life Care
SDMC Form 330 Supplemental Medical Information for End of Life Care

Other required documents related to the procedure:

- Annual Physical Exam (Most recent annual physical)
Most current lab work
Most current EKG (If available)
Most current chest x-ray (If available)
Physician's consult, office notes, scripts, etc.
Any other diagnostic testing or related procedures

Please contact SDMC with any questions at (518) 549-0328.



**Justice Center for the
Protection of People
with Special Needs**

**Declaration
for End of Life Care**

**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 15 – Declarant must sign and date where indicated.

Please avoid the use of abbreviations.

Please return the completed forms by mail or fax to the Justice Center.

For SDMC Use Only:

Part 1. Patient Information

| | | | |
|---|---|---|--|
| Last Name: | | First Name: | |
| Date of Birth: | Age: | Religion: | Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| Street Address: | | | |
| City: | | State: | Zip: |
| Phone: <small>Include area code ()</small> | Ext: | Cell: <small>Include area code ()</small> | Fax: <small>Include area code ()</small> |
| County of Residence: | | | |
| Type of Residence | | | |
| <input type="checkbox"/> Intermediate Care Facility | <input type="checkbox"/> Family Care | <input type="checkbox"/> Individualized Residential Alternative (IRA) | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Community Residence | <input type="checkbox"/> Developmental Center | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Adult Home |
| <input type="checkbox"/> Other Services: _____ | | | |

Part 2a. Declarant

The declarant should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interest for this specific case.

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

Patient Last Name:

For SDMC Use Only:

Part 2b. Alternate Declarant

The alternate declarant will be contacted if the declarant is not available and should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interests for this specific case.

| | | | |
|---|------|---|--|
| Last Name: | | First Name: | |
| Title: | | Email Address: | |
| Agency Name: <small>(Please avoid abbreviations)</small> | | | |
| 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 3. Other Service Providers

Provide information relating to other service providers that are involved in the care of this patient

Part 3a. Nurse

| | | | |
|---|------|---|--|
| Last Name: | | First Name: | |
| Title: | | Email Address: | |
| Agency Name: <small>(Please avoid abbreviations)</small> | | | |
| 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 3b. Residential Manager or Director | Family Care Liaison

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

Patient Last Name:

| |
|---------------------------|
| For SDMC Use Only: |
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Part 3c. Service Coordinator | Social Worker

| | | | |
|---|------|---|--|
| Last Name: | | First Name: | |
| Title: | | Email Address: | |
| Agency Name: <small>(Please avoid abbreviations)</small> | | | |
| 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 3d. Hospice Contact N/A

| | | | |
|---|------|---|--|
| Last Name: | | First Name: | |
| Title: | | Business Email Address: | |
| Agency Name: <small>(Please avoid abbreviations)</small> | | | |
| 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 4. Day Program

| |
|---|
| Agency Name: <small>(Please avoid abbreviations)</small> |
|---|

Part 5. Other Agencies

| |
|---|
| Agency Name(s): List any other agencies providing services not previously mentioned. |
|---|

Patient Last Name:

For SDMC Use Only:

Part 6. Hospital | Nursing Home Contact Provide the following information if the patient has been transferred to a hospital, rehabilitation center or nursing home. N/A proceed to Part 7

Last Name: First Name: Title: Business Email Address: Hospital | Nursing Home Name: Business Address: City: State: Zip: Phone: Ext: Cell: Fax: Pager: Patient's Room Number:

Part 7a. Legally Authorized Surrogates Provide the following information for known surrogates.

Status of the patient's mother: Living (List below) Deceased Whereabouts Unknown Status of the patient's father: Living (List below) Deceased Whereabouts Unknown Check all that apply and list in the box below: Parent Spouse Adult Child Committee of the person Health Care Proxy Guardian Conservator

Are there any actively involved adult family members that have a significant and on-going relationship with the patient sufficient enough to know the care needs of the patient? YES list in the box below NO proceed to Part 8

For any surrogate listed below, please explain why they do not wish to provide informed consent:

Last Name: First Name: Email Address: Relationship: Address: City: State: Zip: Phone: Ext: Cell: Fax:

Patient Last Name:

| |
|---------------------------|
| For SDMC Use Only: |
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| | | | |
|---|---------------------------------------|-----------------------------------|-------------------------------------|
| Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment. | | | |
| <input type="checkbox"/> Does not wish to make decision | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree | <input type="checkbox"/> No Opinion |
| How contacted? | | | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Other: _____ | | |

Part 7b. Legally Authorized Surrogates
Provide the information for any additional surrogates.

| | | | |
|--|------|---|--|
| Last Name: | | First Name: | |
| Email Address: | | Relationship: | |
| Address: | | | |
| City: | | State: | Zip: |
| Phone: <small>Include area code ()</small> | Ext: | Cell: <small>Include area code ()</small> | Fax: <small>Include area code ()</small> |

| | | | |
|---|---------------------------------------|-----------------------------------|-------------------------------------|
| Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment. | | | |
| <input type="checkbox"/> Does not wish to make decision | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree | <input type="checkbox"/> No Opinion |
| How contacted? | | | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Other: _____ | | |

Part 7c. Legally Authorized Surrogates
Provide the information for any additional surrogates.

| | | | |
|--|------|---|--|
| Last Name: | | First Name: | |
| Email Address: | | Relationship: | |
| Address: | | | |
| City: | | State: | Zip: |
| Phone: <small>Include area code ()</small> | Ext: | Cell: <small>Include area code ()</small> | Fax: <small>Include area code ()</small> |

| | | | |
|---|---------------------------------------|-----------------------------------|-------------------------------------|
| Indicate if the above referenced surrogate has an opinion on the proposed treatment or withdrawal of treatment. | | | |
| <input type="checkbox"/> Does not wish to make decision | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree | <input type="checkbox"/> No Opinion |
| How contacted? | | | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Other: _____ | | |

Patient Last Name:

| |
|---------------------------|
| For SDMC Use Only: |
|---------------------------|

Part 8a. Correspondents, Community Advocates or Family Care Provider(s) **N/A** proceed to Part 9

Correspondent means a person who has demonstrated a genuine interest in promoting the best interests of the patient by having a personal relationship with the patient, by participating in the patient's care and treatment, by regularly visiting the patient, or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)].

| | | | |
|--|---------------------------------------|---|--|
| Last Name: | | First Name: | |
| Email Address: | | Relationship: | |
| Address: | | | |
| City: | | State: | Zip: |
| Phone: <small>Include area code ()</small> | Ext: | Cell: <small>Include area code ()</small> | Fax: <small>Include area code ()</small> |
| Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment. | | | |
| <input type="checkbox"/> Agree | | <input type="checkbox"/> Disagree | <input type="checkbox"/> No Opinion |
| How contacted? | | | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Unable to contact | <input type="checkbox"/> Other: _____ | | |

Part 8b. Correspondents, Community Advocates or Family Care Provider(s) **N/A** proceed to Part 9

| | | | |
|---|-------------------------------|---|--|
| Last Name: | | First Name: | |
| Email Address: | | Relationship: | |
| Address: | | | |
| City: | | State: | Zip: |
| Phone: <small>Include area code ()</small> | Ext: | Cell: <small>Include area code ()</small> | Fax: <small>Include area code ()</small> |
| Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment | | | |
| <input type="checkbox"/> Agree | | <input type="checkbox"/> Disagree | <input type="checkbox"/> No Opinion |
| How contacted? | | | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Mail | <input type="checkbox"/> Email | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Other: | _____ | | |

Patient Last Name:

For SDMC Use Only:

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|---|--|
| Part 9. Visit | |
| If the patient cannot attend the hearing, he or she will be visited by at least one panel member. Hospitalized patients are visited. Please explain the medical condition that would prevent the patient from attending the hearing: | |
| Part 10. Supporting Documentation | |
| As the Declarant, I have read the Certification on Capacity for End of Life Care (SDMC Form 310) stating that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Consulting Physician or NYS Licensed Psychologist. | <input type="checkbox"/> YES <input type="checkbox"/> YES |
| As the Declarant, I have read both the Attending Physician Certification for End of Life Care (SDMC Form 320-A) and Concurring Physician Certification for End of Life Care (SDMC Form 320-B) describing the patient's medical condition, the risks, benefits and alternative(s) to the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Concurring Physician. | <input type="checkbox"/> YES <input type="checkbox"/> YES |
| Part 11a. Proposed Withholding | |
| The proposed withholding of life sustaining treatment(s) is/are as follows: See Part 5 of both the Attending Physician Certification for End of Life Care (SDMC Form 320-A) and the Concurring Physician Certification for End of Life Care (SDMC Form 320-B). | |
| Part 11b. Proposed Withdrawal | |
| The proposed withdrawal of life sustaining treatment(s) is/are as follows: See Part 5 of both the Attending Physician Certification for End of Life Care (SDMC Form 320-A) and the Concurring Physician Certification for End of Life Care (SDMC Form 320-B). | |
| Part 11c. Artificial Nutrition and/or Hydration | |
| Has the physician requested to withhold or withdraw life-sustaining artificially provided nutrition or hydration for the patient? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Patient Last Name:

For SDMC Use Only:

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| Part 12. Hospice | |
| Is a Hospice admission anticipated? If the patient has been evaluated by Hospice, please attach the evaluation. | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Part 13. Additional Information | |
| List the title of the person who explained the proposed major medical treatment(s) to the patient. | |
| Describe the efforts to determine the moral and religious beliefs of the patient, and the patient's reaction when the proposed withholding/withdrawal of life sustaining treatment(s) was/were explained. | |
| Based on your <u>personal knowledge</u> of this patient, explain in <u>your own words</u> why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment. | |
| Based on your <u>personal knowledge</u> of this patient, explain in <u>your own words</u> why you believe the proposed treatment decision(s) is/are in the best interest of the patient. | |
| Part 14. Communication Needs | |
| Does the patient understand/speak English? If the patient is a non-English speaker, please indicate the language they speak or understand : | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does the patient require an interpreter? If YES, please indicate type (foreign language, sign language, other): | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Does the patient use a communication board or other assistive device? If YES, please indicate type of assistive device: Please ensure that such device is brought to the hearing. | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Patient Last Name:

For SDMC Use Only:

Part 15. Attestation

This request is based on the patient's qualifying medical condition other than intellectual or developmental disability, with recognition that a person with an intellectual or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without intellectual or developmental disabilities and without any financial considerations that affect the health care provider or any other party.

The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Declarant:

Date:

NOTE:

This form must be dated the same or later than the other forms in this case. This includes the:

- Certification on Capacity for End of Life Care (SDMC Form 310);
- Attending Physician Certification for End of Life Care (SDMC Form 320-A);
- Concurring Physician Certification for End of Life Care (SDMC Form 320-B);
- Supplemental Medical Information for End of Life Care (SDMC Form 330).