



Justice Center for the Protection of People with Special Needs

Certification on Capacity for End of Life Care

SDMC
401 State Street
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 2 & 3 – An attending Physician, in consultation with another Physician or NYS Licensed Psychologist must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Patient Information			
Last Name:		First Name:	
Part 2. Attending Physician			
Last Name:		First Name:	
Email Address:		Professional License Number:	
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Cell: <small>Include area code ()</small>	Fax: <small>Include area code ()</small>
a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability:			
b. The extent and probable duration of this intellectual disability or incapacity is:			
c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.)			
Signature of Attending Physician:		Date:	

Patient Last Name:

For SDMC Use Only:

Part 3. Consulting Physician or NYS Licensed Psychologist

Last Name: _____ First Name: _____

Email Address: _____ Professional License Number: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Cell: _____ Fax: _____
Include area code () Include area code () Include area code ()

Check all that apply:
 Consulting Physician NYS Licensed Psychologist Date of Examination of Patient: _____

a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability:

b. The extent and probable duration of this intellectual disability or incapacity is:

c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.)

d. Summarize the clinical evaluation, including the patient's reaction when you explained the proposed withholding/withdrawal of life sustaining treatment(s) that validates your opinion regarding the patient's decision making ability.

It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding the proposed withholding/withdrawal of life sustaining treatment(s). The information and statements which I have provided are to the best of my knowledge, complete and truthful.

Signature of Physician | NYS Licensed Psychologist: _____ Date: _____

Patient Last Name:

For SDMC Use Only:

Part 4. Attestation

A request for a decision to withdraw or withhold life sustaining treatment requires one of the above providers; attending physician, consulting physician or NYS licensed psychologist to meet one of the following criteria:

Print

Last Name:

Print

First Name:

Check all that apply:

- Employed by a Developmental Disability Services Office as defined in Mental Hygiene Law § 13.17
- Has been employed for a minimum of two years to render care and services in a Program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD).
- Has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD)

Signature of Physician | NYS Licensed Psychologist:

Date: