



Justice Center for the Protection of People with Special Needs

Concurring Physician Certification 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 9 - The Concurring Physician must complete, sign and date where indicated.

For SDMC Use Only:

Part 1. Is an Expedited Review necessary? YES NO
The withholding or withdrawing of life sustaining treatment is requested within 10 days.

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

Part 2. Patient Information

Last Name: First Name:

Part 3. Concurring Physician

Last Name: First Name:

Professional License Number:

Business Address:

City: State: Zip:

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

Part 4. Findings

Date of Examination of Patient:

As a result of my examination, I have determined, to a reasonable degree of medical certainty, that the patient has been diagnosed with the following medical conditions:

- Check all that apply; at least one box must be checked:
A terminal condition where the patient has an illness or injury from which there is no recovery and which reasonably can be expected to cause death within one year; or
Permanent unconsciousness; or
A medical condition other than intellectual or developmental disability which requires life-sustaining treatment, is irreversible, and which will continue indefinitely.

Patient Last Name:

For SDMC Use Only:

Part 5. Request

a. Based on the patient's medical diagnosis, I request consent to WITHHOLD the following life-sustaining treatment(s). Please provide the exact wording that should be written on the SDMC consent form. (To WITHHOLD treatment means to not initiate or provide treatment.)

DNR Order: Do not attempt Resuscitation YES NO

DNI: Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. YES NO

Withhold future hospitalizations unless pain or severe symptoms cannot otherwise be controlled YES NO

Withhold Antibiotics YES NO

Withhold Vasopressors to support blood pressure YES NO

Please list any additional life-sustaining treatment that should be withheld:

Based on the patient's medical diagnosis, I request consent to WITHDRAW the following life-sustaining treatment(s). Please provide the exact wording that should be written on the SDMC consent form. (To WITHDRAW treatment means to stop or remove treatment.)

Withdraw Mechanical Ventilation YES NO

Withdraw Antibiotics YES NO

Withdraw Vasopressors to support blood pressure YES NO

Please list any additional life-sustaining treatment that should be withdrawn:

b. I find that the life-sustaining treatment(s) listed above would impose an EXTRAORDINARY BURDEN on the patient in light of the patient's medical condition. (Please describe the EXTRAORDINARY BURDEN the above life-sustaining treatments pose to the patient. If available, list any test or supporting information that confirm your findings. Include copies of medical records, progress notes, consultations or other relevant reports.)

c. Is this a request to WITHHOLD or WITHDRAW life-sustaining artificially provided nutrition **NO** – proceed to 5e or hydration for the patient?

If YES, I find to a reasonable degree of medical certainty that:

There is no hope of maintaining life; or

The artificially provided nutrition or hydration would impose an extraordinary burden on the patient.

Patient Last Name:

For SDMC Use Only:

d. If reasons to withhold and/or withdraw life sustaining artificially provided nutrition differ from 5b above, describe the **EXTRAORDINARY BURDEN** of providing artificial hydration or nutrition to the patient, and any diagnostic testing/examinations that confirm this recommendation. Include copies of reports.

e. Do you anticipate a Hospice admission?
If YES, please include the hospice evaluation with the submission of this form, if available. YES NO

Part 6. Expected Outcome

Describe the expected outcome of providing or continuing life-sustaining treatment(s) to the patient and, if available, list any tests or information that confirms these findings. Include copies of medical records, progress notes, consults or other relevant reports.

Part 7. Justification

In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

Part 8. Alternatives

Is there an alternate procedure available to this patient that will preserve, improve or restore the patient's health? YES NO

If YES, please state the procedure.

Please explain the rejection of this alternate procedure.

Part 9. Attestation

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

Signature of Concurring Physician:

Date: