NEW YORK STATE OF OPPORTUNITY. | Justice Center for the Protection of People with Special Needs

Related Medical Information For Major Medical Treatment

SDMC
401 State Street
Schenectady, NY 12305
SDMC: (518) 549-0328
sdmc@justicecenter.ny.gov

INSTRUCTIONS:

- Please complete the fillable form below, print the form and sign in black ink. All parts of this form must be completed and returned to the declarant to be submitted with all declaration forms.
- **Please remember to attach:** consults, progress notes, latest annual physical exam, results of diagnostic tests and other documentation related to the proposed major medical treatment(s) being requested
- Always call SDMC at (518) 549-0328 to confirm receipt

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. *(may attach a list of medications)*

Current medication	Dosage	Frequency	Mode of Intake

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:

Part 4. Exams and Tests

a. Date of most recent annual physical examination. *Please include a copy of the most recent physical*.

Date: _____

b. List any current abnormal test or exam results related to the requested procedure: ☐ **N/A**

c. Date of most recent EKG. *Please include a copy if available.* ☐ **N/A**

Date: _____

d. Date of most recent chest x-ray. *Please include a copy if available.* ☐ **N/A**

Date: _____

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): ☐ **N/A**

b. List any major illness, surgery, and/or hospitalizations in the last year: ☐ **N/A**

c. List any other known physical conditions or medical diagnoses: ☐ **N/A**

Part 6. General Anesthesia

Has the patient had general anesthesia before? ☐ Yes ☐ No ☐ Unknown

(Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.)

Patient Last Name:

For SDMC Use Only:

Part 7. Consent Period Requested

7. Is the requested procedure(s) scheduled? ☐ **Yes Scheduled on:** _____ ☐ **No**

Length of Time Requested on the Consent:

**The standard SDMC consent expires in 60 (sixty) days.*

◯ **60 days*** ◯ **90 days** *(see below)* ◯ **120 days** *(see below)* ◯ **180 days** *(see below)* ◯ **365 days** *(see below)*

If a consent period longer than 60 days is needed, please indicate the reason for the request:

☐ **Medical Need** for longer consent - patient will need long-term treatment or multiple treatments/ procedures on this request

☐ **Scheduling-** A longer consent is requested in order to accommodate 60+ days needed to obtain an appointment or complete the procedure/treatment

Other:

Part 8. Prior SDMC Review or Previous Decision-Maker

Has the patient been previously reviewed by SDMC? ☐ **YES** ☐ **NO*** ☐ **Unknown**

***If the patient has not come to SDMC for Consent before, who previously provided consent**?
(if known)

Part 9. Form Submitter's Contact Information

Please Print Last Name:		*Please Print* First Name:	
Email Address:			
Agency Name: (Please avoid abbreviations)			
Workplace Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 10. Attestation

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

Signature of Person Submitting the Form: _____ Date: ___/___/___

MM DD YEAR

PLEASE REMEMBER TO ATTACH

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

- Consults
- Progress notes
- Annual Physical Exam
- Results of diagnostic tests related to medical request