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

Form Checklist for End of Life Care Decisions

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460 (call to confirm receipt)
Email: SDMC@justicecenter.ny.gov

For SDMC Use Only:

INSTRUCTIONS:

- Please complete fillable forms, print the forms and sign in black ink.
- All SDMC forms must be completed and submitted with the required supporting documentation.
- Retain a copy for your records
- Please send by mail, secure email (sdmc@justicecenter.ny.gov) or by fax: 518 549-0460

Always call SDMC at 518 549-0328 to confirm receipt

Be sure to include all four (4) declaration forms fully completed:

✓ **SDMC Form 300** Declaration for End of Life Care

✓ **SDMC Form 310** Certification on Capacity for End of Life Care

✓ **SDMC Form 320A-B** Attending Physician and Concurring Physician Certification for End of Life Care

✓ **SDMC Form 330** Related Medical Information for End of Life Care

Please remember to include the following supplemental medical information to support the declaration for an End of Life Care Decision:

✓ The patient's most recent hospital admission History and Physical; Discharge summary; or a copy of the most recent physical exam if the patient is not hospitalized at this time

✓ Copies of diagnostic testing reports or testing related to the end of life care request

✓ Physician's consult(s), regarding treatment and/or prognosis

✓ Copies of patient's most current lab results

✓ Most current chest x-ray and ECG *(If available)*

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

NEW YORK STATE OF OPPORTUNITY. | 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 four declaration forms must be completed and submitted with the required supporting documentation
- Please type or print in black ink
- Part 13 – Declarant must sign and date where indicated
- Please send by mail, secure email (sdmc@justicecenter.ny.gov) or by fax: 518-549-0460

Always call SDMC at 518 549-0328 to confirm receipt

For SDMC Use Only:

Part 1. Patient Information

Last Name: Doe		First Name: Michael	
Date of Birth: 05/13/1946	Age: 72	Religion: *optional* Methodist	Sex: ☑ MALE ☐ FEMALE
Street Address: 2 Woods Lane			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-6543	Ext:	Fax: Include area code	Cell: Include area code

COUNTY of Patient's Residence Schenectady

Type of Residence

☐ Intermediate Care Facility ☐ Family Care ☑ Individualized Residential Alternative (IRA) ☐ Nursing Home

☐ Community Residence ☐ Developmental Center ☐ Assisted Living ☐ Adult Home ☐ Waiver

☐ Other Services: _____

Part 2a. Declarant (Required) *The declarant must also sign the attestation on page 8*

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: Smith		First Name: Florence	
Title: RN, CMHN		Email Address: Florence.Smith@state. gov	
Agency Name: (Please avoid abbreviations) Provider Agency LLC			
Work Mailing Address: 1 Adirondack Path			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-1234	Ext: 123	Fax: Include area code (555) 555-1235	Cell: Include area code (555) 555-9874

If the patient is hospitalized, please provide the residential contacts (residential nurse, house manager, and care coordinator/care manager) where indicated on this declaration.

Patient Last Name: Doe

For SDMC Use Only:

*The **alternate declarant below** 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.*

Part 2b. Alternate Declarant (Required)	THIS CANNOT BE THE SAME PERSON LISTED AS THE DECLARANT IN 2a. [This could be the Agency RN, Residential Manager, Care Coordinator, or other agency staff]		
Last Name: Blake		First Name: Clara	
Title: RN, Nurse Supervisor		Email Address: Clara.Blake@state.ny.gov	
Agency Name: (Please avoid abbreviations) Provider Agency LLC			
Work Mailing Address: 1 Adirondack Path			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-1213	Ext: 456	Fax: Include area code (555) 555-1236	Cell: Include area code (555) 555-9876
Part 3. Service Providers Provide information relating to other service providers that are involved in the care of this patient			
Part 3a. Agency/Residential Nurse or Nursing Home Primary Nurse assigned to patient's care			
Last Name: See Declarant/RN		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code
Part 3b. Residential Manager | Family Care Liaison | or Director of Nursing Home			
Last Name: Burger		First Name: Paul	
Title: Residential Manager		Email Address: Paul.Burger@agency.ny.com	
Agency/Residence or Name of Nursing Home: Adirondack Agency, Inc.			
Work Mailing Address: 2 Woods Lane			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-6543	Ext:	Fax: Include area code (555) 555-8888	Cell: Include area code (555) 555-8520

Patient Last Name: Doe

For SDMC Use Only:

Part 3c. Care Manager | Care Coordinator | Social Worker | Service Coordinator

Last Name: Jones		First Name: Emily	
Title: MSC		Email Address: EJones@SCAgency.com	
Agency Name: (Please avoid abbreviations) Service Coordination Agency of the North Country			
Work Mailing Address: 10 Main Street			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-3333	Ext: 2283	Fax: Include area code (555) 555-0123	Cell: Include area code (555) 555-9999

Part 3d. Hospice Contact

(*If a hospice admission is anticipated, please include the hospice contact below)* ☐ **NA**

Last Name: Smith		First Name: Samuel	
Title: RN/Hospice Intake		Email Address: SSmith@Hospice.com	
Hospice Name: (Please avoid abbreviations) Hospice Services			
Work Mailing Address: 19 South Street,Schenectady, NY 12305			
Phone: Include area code (555) 555-2222	Ext: 99	Fax: Include area code (555) 555-7770	Cell: Include area code (555) 555-6012

Part 3e. Hospital | Nursing Home Contact

[Preferably a case manager, social worker, or discharge planner is listed in Part 3e.]

Provide the following information if the patient is hospitalized, or presently in a rehabilitation center or nursing home ☐ **NA**

Last Name: Sheraton		First Name: Henry	
Title: Hospital Case Management/SW		Business Email Address: SheratonH@AdirondackHospital.org	
Hospital | Nursing Home Name: Adirondack Hospital			
Address of Hospital/Nursing Home: 2 Mountain Lane			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-5555	Ext: 9265	Fax: Include area code (555) 555-5551	Cell: Include area code (555) 555-8745
Pager: Include area code (555) 555-9630		Patient's Room Number: B 205	

The Hospital or Nursing Home Contact person listed above in 3e. will be asked to assist in obtaining copies of medical information relevant to the case and also with reserving a room at the hearing location if the patient is in a hospital or nursing home.

Patient Last Name: Doe

For SDMC Use Only:

Part 4. Other Agencies Providing Services for the Patient *(i.e. day program, respite, senior center or care coordination)*

- Please list any other agencies providing services for the patient if not previously listed on this declaration: *(not medical clinics or service providers)* Forest Day Program

Part 5a. Legally Authorized Surrogates
Provide the following information for known surrogates:

Status of the patient's mother:	☐ Living *(List below in 5b)*	☑ Deceased	☐ Whereabouts Unknown
Status of the patient's father:	☐ Living *(List below in 5b)*	☑ Deceased	☐ Whereabouts Unknown

If the patient has any of these possible decision-makers, please complete 5b.

Actively involved is defined as having significant and ongoing involvement so as to have knowledge of the person's needs.

- Health Care Proxy
- Guardian
- Actively Involved Spouse
- Actively Involved Parent
- Actively Involved Adult Child
- Actively Involved Adult Sibling
- Other Actively Involved family member

5b. Surrogate Information:

Please identify the possible surrogate and provide information to explain why the surrogate does not wish or is not able to make the decision:

(attach an additional page if there is more than one surrogate)

Last Name: Doe	First Name: Robert	Relationship: Brother
Mailing Address: 18 Main Street		
City: Albany	State: NY	Zip: 12205
Email Address: RobertDoe@email.com		
Phone: (555) 555-7535	Ext:	Fax:	Cell: (555) 555-4258

- **Please indicate if the surrogate has an opinion on the proposed treatment or withdrawal of treatment?**

☑ Unknown opinion ☐ Does not wish to make the decision ☐ Agrees ☐ Disagrees

- **When (*date*) and how (*phone, mail, email, etc.*) was the surrogate last contacted?**

10/12/2018: Phone Call. Left voicemail message; no response

- **If attempts to contact the surrogate were unsuccessful, please describe the attempts made and the approximate dates and method of contact:**

10/07/2018: Phone call; left voicemail message. No response.
10/09/2018: Email. No response.
10/10/2018: Phone call; left voicemail message. No response.
10/10/2018: Mail. No response.

If there are additional surrogates, please include the surrogate information on an additional page

Patient Last Name: Doe

For SDMC Use Only:

Part 6. Correspondent, Community Advocate or Family Care Provider

☐ **N/A** proceed to Part 7

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: Potter		First Name: Sara	
Email Address:		Relationship: former staff person	
Address: 25 Main Street			
City: Adirondack		State: NY	Zip: 14210
Phone: Include area code (555) 555-3570	Ext:	Fax: Include area code	Cell: Include area code

Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment.

☑ Agrees ☐ Disagrees ☐ Unknown

How was the correspondent last contacted? ☑ Phone ☐ Mail ☐ Email ☐ In Person

Attempts to contact the correspondent on the following date(s) were unsuccessful *:* ☐ Other: _____

Part 6b. Correspondents, Community Advocates or Family Care Provider(s)

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

- Does the correspondent have a known opinion on the proposed treatment or withdrawal of treatment?

☐ Agrees ☐ Disagrees ☐ Unknown

How was the correspondent last contacted? ☐ Phone ☐ Mail ☐ Email ☐ In Person

Attempts to contact the correspondent on the following date(s) were unsuccessful: ☐ Other:

Patient Last Name: Doe

For SDMC Use Only:

Part 7. The SDMC Hearing

If the patient is hospitalized, the SDMC hearing will be held at the hospital.
At least one SDMC panel member will visit the patient to observe and interview the patient prior to the hearing, as required by regulation.

The patient is presently hospitalized and will need to be visited by a panel member prior to the hearing: ☑

The patient is not presently hospitalized and the hearing may be held at the patient's home: ☐

Part 8. Supporting Documentation Review [REQUIRED]

- **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.

☑ **YES** *I have reviewed the Capacity Certification*

- **As the Declarant, I have read the Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-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.

☑ **YES** *I have reviewed the Medical Certification*

Part 9a. Proposed Treatment to be Withheld and/or Withdrawn

- The proposed withholding and withdrawal of life sustaining treatment(s) is/are as follows:

See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B)

DNR/DNI: Withhold Artificial Nutrition and Hydration and IV Fluids; Withhold Vasopressors; Withhold future hospitalizations unless pain or severe symptoms cannot otherwise be controlled.

Withdraw Mechanical Ventilation; Withdraw Artificial Nutrition and Hydration and IV fluids; Withdraw Vasopressors

Part 9b. Artificial Nutrition and/or Hydration:

- Has the physician requested to withhold/withdraw life-sustaining artificially provided nutrition or hydration for the patient? ☑ **YES** ☐ **NO**

Part 10. Hospice

- Is a Hospice admission anticipated? ☑ **Yes** ☐ **No** *If the patient has been evaluated by Hospice already, please attach the evaluation.*

Part 11. Additional Information ***[Required by the Health Care Decisions Act, SCPA Article 17-A, § 1750-b]***

- List the title of the person that explained the proposed treatment decision to the patient: MD

- 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:

Michael just blinked and fell back asleep. He has never expressed interest in attending any religious services. His file indicates that he is Methodist.

Patient Last Name: Doe

For SDMC Use Only:

Part 11. Additional Information, continued

- Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment.

Michael is no longer responsive, he opens and closes his eyes and blinks, but it does not appear to make any response to our questions. Patient has end stage dementia and is nonverbal.

- Based on your personal knowledge of this patient, explain in your own words why you believe the proposed treatment decision(s) is/are in the best interest of the patient.

Since his last episode of aspiration pneumonia, Michael's condition has declined. He is very weak and not interested in eating. Hospice can be provided in his IRA. If he had to be transferred to a setting for more advanced skilled nursing care (such as a feeding tube), he would be with unfamiliar people, in an unfamiliar environment, which would be very distressing for him. Continued LST would prolong his life, but not improve the quality of his life.

Part 12. Communication Needs

Please check all that apply

Does the patient understand English? ☑ Yes ☐ No

Does the patient speak English as his/her primary language? ☑ Yes ☐ No

If the patient is a non-English speaker, please indicate the language that is spoken or understood:

Does the patient require an interpreter for sign language or for a language other than English? ☐ Yes* ☑ No

***If YES**, please indicate type (foreign language, sign language, other):

Is the patient able to verbally communicate his/her needs? ☐ Yes ☑ No

- ☑ Patient is nonverbal or unable to verbally communicate (due to medical condition such as heavy sedation, unconsciousness, or intubation)
- ☐ Patient is able to point or gesture to make needs known
- ☐ The patient's expressive skills are limited.

Comments: Communicates through gestures and facial expressions

Part 13. Attestation by the Declarant

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 accurate and truthful, to the best of my knowledge.

Signature of Declarant: *Florence Smith, RN, CMHN*

Date: 10 / 12 / 2018 (MM / DD / YEAR)

Declarant is listed on page 1, Part 2a

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

Please submit this declaration together with the following:

- Certification on Capacity for End of Life Care (SDMC Form 310); and
- Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B); and
- Related Medical Information for End of Life Care (SDMC Form 330); and
- Supplemental medical information to support the declaration for an end of life care decision.

REMINDER:

- The OPWDD MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed after the SDMC End of Life hearing
- Notifications per SCPA § 1750-b are required

NEW YORK STATE OF OPPORTUNITY. | 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
Questions: 518-549-0328

INSTRUCTIONS:

- Please complete 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.
- **Part 2 & 3** - An attending Physician, in consultation with another Physician or a NYS Licensed Psychologist must complete
- **Part 4 -** Either the attending physician or the consulting physician/or NYS licensed psychologist must meet the additional requirements for experience with ID/DD individuals (see page 3)

For SDMC Use Only:

Part 1. Patient Information

Last Name: Doe		First Name: Michael	
Agency where the Patient Resides or Receives Services: (Please avoid abbreviations) Adirondack Agency, Inc.			
Phone: (555) 555-6543	Ext:	Fax: (555) 555-8888	

Part 2. Attending Physician

Last Name: Phillips		First Name: Carla	
Email Address: CPhillips@Hospital.com		Professional License Number: 001234	
Business Address: 25 Medical Way			
City: Saratoga		State: NY	Zip: 13304
Phone: (555) 555-5555	Ext: 2	Fax: (555) 555-5554	Cell:

Date of examination of patient: 10 / 11 / 2018 (MM / DD / YEAR)

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:

Down Syndrome, Intellectual disability with significant adaptive deficits.

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

Lifelong, since birth.

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.)

No testing records are available at this time.

I am an attending physician for the patient and the information and statements which I have provided are accurate and truthful to the best of my knowledge.

Signature of Attending Physician: *Carla Phillips, MD* Date: 10 / 11 / 2018 (MM / DD / YEAR)

Patient Last Name: Doe

For SDMC Use Only:

Part 3. Consulting Physician or NYS Licensed Psychologist [This cannot be the same physician identified in Part 2.]			
Last Name: Bartlett		First Name: Josiah	
Email Address:		Professional License Number: 0054321	
Business Address: 125 Physicians Drive			
City: Newton		State: NY	Zip: 10121
Phone: Include area code (555) 555-7624	Ext:	Fax: (555) 555-7625	Cell
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:

Down Syndrome and Profound ID. Patient is currently unresponsive.

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

Permanent and irreversible

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.)

N/A

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.

Patient with poor mental capacity. He is minimally responsive. He does not have the capacity to make end of life decisions.

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 accurate and truthful to the best of my knowledge.

Josiah Bartlett, PhD

Signature of Physician | NYS Licensed Psychologist:

Date: 10 / 11 / 2018

MM DD YEAR

Patient Last Name: Doe

For SDMC Use Only:

Please contact SDMC if you are unable to access a physician or NYS licensed psychologist who meets the required qualification in Part 4: 518 549-0328

Part 4. Attestation

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

Print Last Name: Bartlett	Print First Name: Josiah

Check all that apply:

- ☐ Employed by a Developmental Disability Services Office as defined in Mental Hygiene Law § 13.17
- ☐ Have 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)

Josiah Bartlett, PhD

Signature of Physician | NYS Licensed Psychologist:

Date: 10 / 11 / 2018

MM DD YEAR

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

Attending Physician and Concurring Physician Certification for End of Life Care

401 State Street
Schenectady, NY 12305
SDMC Phone: 518-549-0328

INSTRUCTIONS:

- Please complete the fillable form below, print and sign in black ink. All part of this form must be completed and returned to the declarant to be submitted with all declaration forms.
- **Part 4-** Attending and concurring physicians must both sign where indicated
- **Part 10-** Attending and concurring physicians must both sign the attestation

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

The withholding or withdrawing of life sustaining treatment is requested as soon as possible ☑ **YES** ☐ **NO**

If **YES,** you must state the medical condition to support the request.

Patient with prolonged hospitalization and is at risk for further decompensation

Part 2. Patient Information

Last Name: Doe | First Name: Michael

Agency where the Patient Resides or Receives Services: (Please avoid abbreviations) Adirondack Agency, Inc.

Phone: Include area code (555) 555-6543 | Ext: | Fax: Include area code (555) 555-8888

Part 3a. Attending Physician

Last Name: Phillips | First Name: Carla

Professional License Number: 001234

Business Address: 25 Medical Way

City: Saratoga | State: NY | Zip: 13304

Phone: Include area code (555) 555-5555 | Ext: 2 | Cell: Include area code | Fax: Include area code (555) 555-5554

Part 3b. Concurring Physician

Last Name: Black | First Name: Eliza

Professional License Number: 004321

Business Address: 88 Leaf Street

City: Newton | State: NY | Zip: 14001

Phone: Include area code (555) 555-2154 | Ext: 114 | Cell: Include area code (555) 555-2156 | Fax: Include area code (555) 555-5124

Patient Last Name: Doe

For SDMC Use Only:

Part 4. Attending and Concurring Physician Findings **[REQUIRED]**

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 *(briefly describe)*; 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. *(Briefly describe)*

End stage renal disease, end stage dementia

Signature of Attending Physician: *Carla Phillips, MD* Date: 10 / 11 / 2018 (MM / DD / YEAR)

Date of Review or Examination of Patient: 10 / 11 / 2018 (MM / DD / YEAR)

Signature of Concurring Physician: *Eliza Black, MD* Date: 10 / 11 / 2018 (MM / DD / YEAR)

Date of Review or Examination of Patient: 10 / 11 / 2018 (MM / DD / YEAR)

Please include copies of progress notes, medical records, consultation, or other relevant reports to support the patient's medical condition.

The Attending Physician and Concurring Physician must sign and date above.

Patient Last Name: Doe

For SDMC Use Only:

Parts 5-8 are completed by the Attending Physician and reviewed by the Concurring Physician

Part 9 is completed by the Concurring Physician

The Concurring Physician may note additional comments and opinions regarding the life-sustaining treatment and/or the burden of treatment for this patient.

Part 5. Attending and Concurring Physician Request to Withhold/Withdraw Life-Sustaining Treatment:

5a. End of Life Care Treatment Plan

Based on the patient's medical condition, I request consent for the following Medical Orders for Life-Sustaining Treatment:

Please check only the End of Life treatment decisions requested

- [x] **DNR-** withhold CPR
- [x] **DNI**- withhold mechanical ventilation or intubation
- [ ] Withdraw Mechanical Ventilation
- [ ] Withhold Future Hospitalizations unless pain or severe symptoms cannot otherwise be controlled.
- [ ] Withdraw Vasopressors
- [ ] Withhold Vasopressors
- [ ] Withdraw Antibiotics
- [ ] Withhold Antibiotics
- [ ] Antibiotics will be used only to meet the patient's overall treatment goal of providing comfort.

- **PLEASE SPECIFY ANY OTHER LIFE-SUSTAINING TREATMENT(S) TO BE WITHHELD OR WITHDRAWN:**
  (i.e. withhold/withdraw dialysis; withhold blood transfusions)

ARTIFICIAL NUTRITION AND HYDRATION

- [ ] Withhold IV Fluids
- [x] No Feeding Tube *(Withhold placement of a feeding tube for artificial nutrition and hydration)*
- [ ] Withdraw IV Fluids
- [ ] Withhold/Withdraw Artificial Nutrition and/or Hydration

⇨ **If artificial nutrition and/or hydration is to be withheld/withdrawn, the attending physician must find to a reasonable degree of medical certainty that one of the two following conditions are met:** ⇦

- [x] There is no hope of maintaining life OR
- [ ] The artificially provided nutrition or hydration would impose an extraordinary burden on the patient.

If a decision to withhold/withdraw life-sustaining artificial nutrition and/or hydration is checked above, the physician must also document the EXTRAORDINARY BURDEN of providing artificial hydration or nutrition to the patient.

- **Please state the Extraordinary Burden of Providing Artificial Nutrition and/or Hydration to the patient:**
  [Required only if a decision to withhold/withdraw artificially provided nutrition/hydration is requested]

Artificial nutrition and hydration would prolong Mr. Doe's life, but would burden his organs and be futile. Continuing the life-sustaining treatment would prolong his suffering and would offer no benefit or hope of improvement in his prognosis.

5b. I find that the life-sustaining treatment(s) indicated above would impose an EXTRAORDINARY BURDEN on the patient in light of the patient's medical condition. Please state the EXTRAORDINARY BURDEN the life-sustaining treatments pose to the patient. *If available, list any diagnostic tests or medical information that supports your findings.* **[REQUIRED]**

CPR would cause pain, suffering and broken ribs from chest compressions and pain from cardioversion (shock to heart). CPR is unlikely to have much benefit given the patient has end stage kidney disease and end stage dementia.

Patient Last Name: Doe

Parts 5-8 are completed by the Attending Physician and reviewed by the Concurring Physician

Part 9 is completed by the Concurring Physician

The Concurring Physician may note additional comments and opinions regarding the life-sustaining treatment and/or the burden of treatment for this patient.

For SDMC Use Only:

- **COMFORT CARE / HOSPICE SERVICES**

☐ Provide Comfort Care with Hospice Services ☐ Provide Comfort Care

(Comfort Care is defined as medical care and treatment provided with the primary goal of relieving pain, symptoms, and reducing suffering)

PLEASE NOTE:
When Comfort Care is included on an SDMC consent, it does NOT authorize any additional withdrawal or withholding of life sustaining treatment which is not specifically included in the SDMC decision. Any life sustaining treatment to be withheld or withdrawn must be specified on the SDMC consent.

Part 6. Expected Outcome of Continued Life-Sustaining Treatment **[REQUIRED]**

Describe the expected or likely outcome of continued life-sustaining treatment(s) provided for this patient notwithstanding the patient's intellectual or developmental disability.

Please include the potential restoration of functioning or recovery that would be likely if life-sustaining treatment were to be continued indefinitely.

The expected outcome to LST would be a tracheostomy and long term ventilation, pain from the procedure, and likely nursing home placement if he survived the hospitalization. However, chances of survival after CPR is poor.

Part 7. Alternatives **[REQUIRED]**

- 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:

Patient Last Name: Doe

For SDMC Use Only:

Parts 5-8 are completed by the Attending Physician and reviewed by the Concurring Physician

Part 9 is completed by the Concurring Physician

The Concurring Physician may note additional comments and opinions regarding the life-sustaining treatment and/or the burden of treatment for this patient.

Part 8. Justification by Attending Physician **[REQUIRED]**

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

Mr. Doe would require prolonged support if an attempt at resuscitation were made. If ventilator support were to be continued indefinitely, Mr. Doe would need to be transferred to a skilled nursing facility and would not be able to return to his group home and familiar staff. Further life-sustaining treatment such as placement of a feeding tube will extend patient's life, but will not achieve significant recovery for someone with end stage disease (dementia and renal disease) and will not prevent continued aspiration or oral secretions.

Part 9. Justification by Concurring Physician **[REQUIRED]**

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

The withholding of LST is in the best interest of the patient as such interventions are invasive and aggressive and will not achieve significant improvement or recovery with the patient. His quality of life is negatively impacted by his medical condition and will progressively decline.

Part 10. Attestation
(Attending Physician and Concurring Physician must sign and date the attestation) **[REQUIRED]**

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

Signature of Attending Physician: *Carla Phillips, MD* Date: 10 / 11 / 2018 (MM / DD / YEAR)

Signature of Concurring Physician: *Eliza Black, MD* Date: 10 / 11 / 2018 (MM / DD / YEAR)

The Attending Physician and Concurring Physician must both sign and date above.

- The OPWDD MOLST Checklist for Individuals with Developmental Disabilities must be completed after the SDMC End of Life Hearing.
- The Attending Physician is responsible for making the appropriate notifications of the end of life care decision following the hearing.

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

Related Medical Information for End of Life Care

SDMC
401 State Street
Schenectady, NY 12305
Questions: 518-549-0328

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.
- **Part 8** – The person submitting the form must complete, sign and date where indicated
- **Please remember to attach:** consults, progress notes, latest annual physical exam, results of diagnostic tests and other related documentation
- **Please call SDMC at (518) 549-0328 to confirm receipt**

For SDMC Use Only:

Part 1. Patient Information

Last Name: Doe | First Name: Michael

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
Please see attached			
Medical Admin. Record			

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

Depakote

Part 3. Allergies

Any known allergies?

Penicillin, bananas

Patient Last Name: Doe

For SDMC Use Only:

Part 4. Exams and Tests

a. Date of most recent annual physical examination or the hospital admission and history note. Please include a copy of the most recent physical.
Date: 10/07/2018

b. List any abnormal findings from exams and tests: ☐ **N/A**

BUN -26, Creatinine 3.47, Hemoglobin 9.0 Hematocrit 29.4
Albumin >1

c. Date of most recent EKG. Include a copy. ☐ **N/A**

Date: 10/09/2018

d. Date of most recent chest x-ray. Include a copy. ☐ **N/A**

Date: 10/09/2018

e. Date of most recent laboratory tests. Include a copy of the most recent lab work.

Date: 10/09/2018

Part 5. Additional Information

a. List any cardiac or pulmonary condition(s): ☐ **N/A**

Hypertension, diabetes

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

Aspiration pneumonia 02/2018, 04/2018 and 06/2018

c. List any other known physical condition or medical diagnosis:

GERD, seizure disorder, anemia of chronic disease,

Part 6. Prior SDMC Review

Has the patient been reviewed by SDMC previously? ☑ Yes ☐ No ☐ Unknown

Patient Last Name: Doe

For SDMC Use Only:

Part 7. Form Submitter's Contact Information			
Last Name: Smith		First Name: Florence	
Business Email Address: Florence.smith@state.gov		Title: RN, CMHN	
Agency Name: (Please avoid abbreviations) Provider Agency LLC			
Business Address: 1 Adirondack Path			
City: Schenectady		State: NY	Zip: 12305
Phone: Include area code (555) 555-1234	Ext: 123	Fax: Include area code (555) 555-1235	Cell: Include area code (555) 555-9874

Part 8. Attestation

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

Signature of person completing this form: *Florence Smith RN, CMHN*

Date: 10 / 12 / 2018

MM DD YEAR

PLEASE REMEMBER TO ATTACH

Documentation related to the requested End of Life Care:

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

REMINDER:

The OPWDD MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed and all legally required notifications must be made before an SDMC End of Life decision may take effect.