



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 3-** Must be signed and dated by the clinician completing the evaluation.
- **Part 4- If the Capacity Evaluation was not completed by a NYS Licensed Psychologist or Psychiatrist, then Part 4 must be reviewed and co-signed by a NYS Licensed Psychologist or Psychiatrist.**

For SDMC Use Only:

Part 1. Patient Information

Last Name:		First Name:	
Agency where Patient Resides or Receives Services: <small>(Please avoid abbreviations)</small>			
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	

Part 2. Clinician

If the evaluation is being performed by anyone other than a NYS licensed psychologist or psychiatrist, then Part 4 must be co-signed by a NYS licensed psychologist or psychiatrist.

Last Name:		First Name:	
Email Address:			
Business Mailing Address:			
City:	State:	Zip:	
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>

Type of Clinician

NYS-Licensed Psychiatrist
 NYS-Licensed Psychologist
 Other (specify): _____

If "other" is indicated, the attestation must be cosigned

Professional License Number: _____

Date of Examination of Patient | Review of Record: _____

a. As a result of this examination and/or review of records, the patient has been diagnosed with the following intellectual disability or psychiatric diagnosis:

b. If available, please list any psychological testing and results. (Testing is not necessary to complete this form).

Patient Last Name:

For SDMC Use Only:

c. Summarize the clinical evaluation, including the patient's reaction, when you explained the proposed major medical treatment(s) and its risks and benefits, which supports your determination regarding the patient's decision making ability.

Part 3. Attestation Signed by the clinician that completed this Capacity Evaluation-
If evaluator is not a NYS Licensed Psychologist or Psychiatrist, Part 4 must be cosigned by a NYS licensed psychologist or psychiatrist below.

Professional License Number:

Clinician Type:

NYS-Licensed Psychiatrist

NYS-Licensed Psychologist

Other
(specify):

If "other" is indicated, the attestation must be cosigned by a NYS- Licensed psychiatrist or psychologist.

It is my clinical opinion that the patient **DOES NOT** have the capacity to make an informed decisions regarding this major medical procedure/treatment. The information and statements which I have provided are truthful and accurate to the best of my knowledge.

Signature of clinician completing the evaluation

Date: MM/DD/YEAR

Part 4. Co-signer Attestation

Required if the evaluation was performed by a clinician other than a New York State Licensed Psychiatrist or Psychologist.

Last Name:

First Name:

Please Indicate Co-signer's License Information:

NYS-Licensed Psychiatrist

NYS-Licensed Psychologist

Professional License Number:

I concur with the above clinical evaluation.
The information and statements are accurate and truthful to the best of my knowledge.

Signature of the NYS Licensed Psychologist or Psychiatrist reviewing the Evaluation

Date of Review
MM / DD / YEAR