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

Form Checklist for Major Medical Treatment Decisions

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518 549-0460
Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

- Please complete fillable forms, print the form and sign in black ink
- All SDMC forms must be completed and submitted with the required supporting documentation
- Single-sided pages ONLY; no staples
- Retain a copy for your records
- Please send by mail, secure email (sdmc@justicecenter.ny.gov), or by fax: (518)549-0460

For SDMC Use Only:

Always call SDMC at (518) 549-0328 to confirm receipt

Be sure to include all Declaration supporting documents fully completed:

- ☐ **SDMC Form 200** Declaration for Major Medical Treatment
- ☐ **SDMC Form 210** Certification on Capacity for Major Medical Treatment
- ☐ **SDMC Form 220-A** Certification on Need for Major Medical Treatment
- ☐ **SDMC Form 220-B** Related Medical Information for Major Medical Treatment

Please remember to include the following supplemental medical information related to the procedure:

- ☐ Physician's consult, office notes, scripts, etc. supporting the medical procedure requested on Form 220-A
- ☐ Reports for other diagnostic testing related to the procedure or treatment
- ☐ Most recent Annual Physical Exam
- ☐ Most current lab results
- ☐ Most current EKG (if available)
- ☐ Most current chest x-ray (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 Major Medical Treatment

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: sdmc@justicecenter.ny.gov

INSTRUCTIONS:

- Please complete fillable form below, print the form and sign the attestation on page 7 in black ink.
- Submit by secure email (sdmc@justicecenter.ny.gov); fax (518) 549-0460 or mail. If mailing, single-sided pages only; no staples
- Please return all 4 SDMC declaration forms together to SDMC with the required supporting documentation
- Always call SDMC at (518) 549-0328 to confirm receipt in each case

For SDMC Use Only:

Part 1. Patient Information

Last Name:		First Name:	
Date of Birth:	Age:	Religion: *optional*	Sex: ☐ MALE ☐ FEMALE
Street Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

COUNTY of Patient's Residence:

Type of Residence

☐ Intermediate Care Facility ☐ Family Care ☐ Hospital Psychiatric Ward ☐ Nursing Home ☐ Assisted Living

☐ Community Residence ☐ Individualized Residential Alternative (IRA) ☐ OMH-funded or -approved housing ☐ Adult Home ☐ Waiver

☐ Development Center ☐ Psychiatric Center ☐ Other Services: _____

Part 2. Proposed Major Medical Procedure or Treatment

What is the proposed procedure or treatment being sought on behalf of the patient?
(Refer to Part 4 on the SDMC Form 220-A Certification on Need for Major Medical Treatment)

Part 3. Biopsy

Will a biopsy be performed? ☐ **YES** ☐ **NO** ☐ **Possible Biopsy** ☐ **Unknown**

Part 4. Anesthesia

What is the physician's anticipated method of anesthesia, if known?

*Please see **Part 7, page 2** on the Certification on Need for Major Medical Treatment (SDMC Form 220-A).*

☐ **IV Sedation or MAC**

☐ **Unknown*** ☐ **None** ☐ **Local** ☐ **General Anesthesia**

**If unknown at this time, please consult with physician. This will be discussed at the hearing.*

Patient Last Name:

For SDMC Use Only:

The declarant identified in Part 5a below must also sign the attestation on page 7.

Part 5a. Declarant [Required]
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:		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 5b. Alternate Declarant (Required) THIS CANNOT BE THE SAME PERSON LISTED ABOVE AS THE DECLARANT
The alternate declarant 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.

Last Name:		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 5c. Agency/Residential Nurse

Last Name:		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

Patient Last Name:

For SDMC Use Only:

Part 5d. Residential Manager | Family Care Liaison | Director of Nursing Home			
Last Name:		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 5e. Care Manager | Care Coordinator | Social Worker | Service Coordinator			
Last Name:		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 5f. Hospice Contact ☐ Not Applicable			
Last Name:		First Name:	
Title:		Email Address:	
Hospice Name and Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 5g. Hospital | Nursing Home Contact (Case Manager, Social Worker, Discharge Planner) ☐ NA Provide the following information if the patient has been transferred to a hospital, rehabilitation center or nursing home			
Last Name:		First Name:	
Title:		Email Address:	
Hospital | Nursing Home Name:			
Hospital/Nursing Home Street Address:			

The hospital/nursing home contact person identified above will be asked to assist in obtaining medical information relevant to the case and also to reserve a room for the hearing at the hospital or nursing home.

(continued on next page)

Patient Last Name:

For SDMC Use Only:

Hospital or Nursing Home Contact Information, cont'd:

City:		State:	Zip:
Phone: Include area code	Ext:	Fax:	Cell:
Pager: (Include area code)		Patient's Room Number:	

Part 6. Other Agencies Providing Services for the Patient

Please list any other agencies providing services for the patient if not previously listed on this declaration:*(i.e. day program- Not Medical Services or Clinics*)

Part 7a. Legally Authorized Surrogates
Provide the following information for known surrogates.

Status of the patient's mother: ☐ Living (*list below in 7b*) ☐ Deceased ☐ Whereabouts Unknown
Status of the patient's father: ☐ Living (*list below in 7b*) ☐ Deceased ☐ Whereabouts Unknown

If Patient has any possible surrogates, please list in 7b below:

Possible Surrogates:

- Parent
- Health Care Proxy
- Sibling
- Spouse
- Guardian
- Adult Child
- Other family member per OPWDD or OMH regulations (see below)

For current or former OPWDD patients ONLY:
Are there any actively involved adult family members who have a significant and on-going relationship with the patient enough to know the care needs of the patient? ☐ **YES** ☐ **NO** ☐ **N/A**

For OMH/OASAS patients ONLY:
Is there a legally authorized surrogate? This includes a parent, spouse or adult child of the patient. ☐ **YES** ☐ **NO** ☐ **N/A**

7b. 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 additional page if needed)

Last Name: First Name: Relationship:

Mailing Address:

Email Address: Phone: (Include area code)

- **Please indicate if the surrogate has a known opinion regarding the proposed 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?**

- **If attempts to contact the surrogate were unsuccessful, please describe the attempts made and approximate date(s) and method of contact:**

Please attach an additional page if there are additional surrogates.

Patient Last Name:

For SDMC Use Only:

Part 8a. Correspondent, Community Advocate or Family Care Provider

A Correspondent is 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 or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)]:

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

Indicate if the correspondent has an opinion on the proposed treatment.

☐ Agree ☐ Disagree ☐ Unknown

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

Attempts to contact the correspondent on the following date(s) were unsuccessful *(include details):*

Part 8b. Other Correspondents, Community Advocates or Family Care Provider(s):

(attach additional page if needed)

Last Name:	First Name:	
Email Address:	Relationship:	
Mailing Address:		
City:	State:	Zip:
Phone:	Fax:	Cell:

Please indicate if the correspondent has an opinion on the proposed treatment:

☐ Agree ☐ Disagree ☐ Unknown

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

Attempts to contact the correspondent on the following date(s) were unsuccessful *(include method of contact):*

Patient Last Name:

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

- *Certification on Capacity for Major Medical Treatment (SDMC Form 210);*
- *Certification on Need for Major Medical Treatment (SDMC Form 220-A);*
- *Related Medical Information for Major Medical Treatment (SDMC Form 220-B).*

For SDMC Use Only:

Part 9a. Supporting Documentation Review [REQUIRED]

As the Declarant, I have read the Certification on Capacity for Major Medical Treatment (SDMC Form 210) that has been completed by a NYS Licensed Psychiatrist or NYS Licensed Psychologist.	☐ Yes

Part 9b. Supporting Documentation Review [REQUIRED]

As the Declarant, I have read the Certification on Need for Major Medical Treatment (SDMC Form 220-A) that has been completed by a Physician | Dentist | Podiatrist. (Circle One)	☐ Yes

Part 10. Additional Information Required:

List the **TITLE** (i.e. Dr., RN, Care Coordinator) of the person who explained the proposed major medical treatment(s) to the patient:

Describe the patient's reaction, if any, when the treatment(s) was/were explained, and any opinions expressed:

Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent for this procedure:

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

Part 11. Communication Needs:

Does the patient understand English?
☐ Yes ☐ No
Does the patient speak English as their primary language?
☐ Yes ☐ No

Patient is nonverbal* ☐
*If the patient is nonverbal, or has limited expressive language, how does the patient communicate his/her needs?

If the patient is a non-English speaker, please indicate his/her primary language: _____

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

*If YES, please indicate the type of interpreter needed (language, ASL): _____

If the patient uses a communication board or other assistive device, the communication device must be brought to the hearing

Part 12. The SDMC Hearing ***MHL Article 80 requires the patient to be present at the hearing, if able.***

Is there a medical condition that would prevent the patient from attending the hearing? ☐ Yes ☐ No
If yes, please description below. Alternative arrangements for the panel to meet with the patient will be made.

Part 13. Attestation by the Declarant

The information and statements which I have provided are truthful and accurate to the best of my knowledge.

SIGNATURE of the Declarant:_____ Date: ___/___/___
(Declarant is listed under Part 5a; page 2 of 7) MM/DD/YYYY

This attestation must be signed by the declarant and dated AFTER all other supporting documents have been reviewed by the declarant.