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:<br>(Please avoid abbreviations) | | | |
| **Work** Mailing Address: | | | |
| City: | | State: | Zip: |
| Phone:<br>Include area code | Ext: | Fax:<br>Include area code | Cell:<br>Include area code |

| **Part 5e. Care Manager \| Care Coordinator \| Social Worker \| Service Coordinator** | | | |
|---|---|---|---|
| Last Name: | | First Name: | |
| Title: | | Email Address: | |
| Agency Name:<br>(Please avoid abbreviations) | | | |
| **Work** Mailing Address: | | | |
| City: | | State: | Zip: |
| Phone:<br>Include area code | Ext: | Fax:<br>Include area code | Cell:<br>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:<br>Include area code | Ext: | Fax:<br>Include area code | Cell:<br>Include area code |

| **Part 5g. Hospital \| Nursing Home Contact (Case Manager, Social Worker, Discharge Planner)** ☐ NA<br>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.**

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

# Certification on Capacity for Major Medical Treatment

**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 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: (Please avoid abbreviations) | | |
| Phone: Include area code | Ext: | Fax: Include area code |

## 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: Include area code | Ext: | Fax: Include area code | Cell: Include area code |

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** have the capacity to make an informed decision regarding this major medical procedure/treatment.

◯ **DOES NOT** have the capacity to make an informed decision 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

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

# Certification on Need for Major Medical Treatment

**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 together with all declaration forms.
- **Part 10** – Physician must complete, sign and date where indicated
- **Part 11** - Co-signature required if Parts 3-10 are completed by a clinician other than a physician, dentist, or podiatrist

**For SDMC Use Only:**

**Part 1. Is an Expedited Review necessary?**
*Is the proposed treatment of an urgent need that is expected to be performed within 10 days.*

☐ **YES*** ☐ **NO**

If YES*, please identify the acute medical diagnosis and or current medical condition to support the expedited request:

**Part 2. Patient Information**

| Last Name: | First Name: |
|---|---|

Agency where the Patient Resides or Receives Services:
(Please avoid abbreviations)

| Phone: Include area code | Ext: | Fax: Include area code |
|---|---|---|

**Part 3.Physician/Dentist/Podiatrist** *If Parts 3- 10 of this form are completed by a clinician other than an MD, DDS, or DPM, Part 11 must be co-signed*

| *Please Print* Last Name: | First Name: |
|---|---|

Professional License Number:

Business Address:

| City: | State: | Zip: |
|---|---|---|

| Phone: Include area code | Ext: | Fax: Include area code | Cell: Include area code |
|---|---|---|---|

**Part 4. Proposed Major Medical Procedure or Treatment**

Date of Review or Examination of Patient: ____/____/____
MM DD YEAR

I request informed consent for the following medical treatment(s) and/or procedure(s):

*Please include the medical procedure(s) and/or treatment(s) with the specific wording the physician would like on the consent*

**Patient Last Name:**

**For SDMC Use Only:**

**Part 5. Biopsy**

Do you anticipate performing a biopsy?

☐ **YES -** Type: _____ ☐ **POSSIBLE BIOPSY**

☐ **No** ☐ **UNKNOWN**

**Part 6. Request**

a. The following diagnostic tests/examinations have been performed to confirm my recommendation(s).
*Please include copies of reports*.

b. Clinical indications for the requested proposed major medical treatment(s):

c. In my clinical opinion, the risks specific to this proposed major medical treatment(s) is/are:

d. In my clinical opinion, the benefits specific to this proposed major medical treatment(s) is/are:

**Part 7. Anesthesia**

**Please indicate the anticipated form of anesthesia to be used for the procedure or treatment:**

☐ IV Sedation

☐ Monitored Anesthesia Care (MAC)

☐ Local Anesthesia or Novocaine

☐ None or N/A

☐ General Anesthesia *(The patient will be unconscious and intubated during the treatment)*

When the treatment plan does not include general anesthesia, if on the day of the proposed major medical treatment(s) the use of general anesthesia becomes necessary, Public Health Law Section 2805-d provides for the disclosure of reasonably foreseeable risks.

Common/severe complications of general anesthesia include: hoarseness, nausea, sore throat, broken teeth, tracheal or esophageal injuries, respiratory distress, cardiac failure and death. (Source: American Society of Anesthesiologists)

❖ Surrogate Decision-Making consent is conditioned upon a current preoperative screening in accordance with sound medical practice to determine the suitability of the patient to withstand the major medical procedure and the recommended form of anesthesia on the day of the procedure.

**Part 8. Alternative Procedures**

- Is there an alternate procedure that is less invasive available to this patient?
  *If **YES**, please note the procedure(s) below.

☐ **YES*** ☐ **NO**

**Patient Last Name:**

**For SDMC Use Only:**

Please explain the rejection of this alternative procedure.

**Part 9. Risks**

What are the risks of non-treatment?

**Part 10. Attestation of the Health Care Provider Who Completed the Evaluation***

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

_____ Date: / /

Signature of Health Care Provider MM DD YEAR

**If the medical certification has not been completed by a licensed physician or dentist, this attestation must be co-signed below.*

**Part 11. Co-signer Attestation**

If the evaluation has been performed by OTHER than a licensed physician, dentist or podiatrist, this form must be CO-SIGNED below.

| *Print* Last Name: | *Print* First Name: |
|---|---|
| Check all that apply: ☐ Licensed Physician ☐ Licensed Dentist ☐ Licensed Podiatrist | Professional License Number: |

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

_____ Date: / /

Signature of the Co-signing Licensed Physician/Dentist/Podiatrist: MM DD YEAR

- Please note, the name of the licensed physician, dentist, or podiatrist who signs the 220-A will be listed on the SDMC consent. The SDMC consent is not restricted to that health care provider. Mental Hygiene Law § 80.07(f) provides:

  If the panel determination consents to such treatment, such consent shall constitute legally valid consent to such treatment in the same manner and to the same extent as if the patient were able to consent to or refuse such treatment on his or her own behalf.

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