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