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.