



**Justice Center for the
Protection of People
with Special Needs**

**Form Checklist for
End of Life Care Decisions**

SDMC

401 State Street

Schenectady, NY 12305

Fax: 518-549-0460 (call to confirm receipt)

Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

- Please complete fillable forms, print the forms 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 four (4) declaration forms fully completed:

SDMC Form 300	Declaration for End of Life Care
SDMC Form 310	Certification on Capacity for End of Life Care
SDMC Form 320AB	Attending Physician and Concurring Physician Certification for End of Life Care
SDMC Form 330	Related Medical Information for End of Life Care

Please remember to include the following supplemental medical information to support the declaration for an End of Life Care Decision:

The patient's most recent hospital admission History and Physical; Discharge summary; or a copy of the most recent physical exam if the patient is not hospitalized at this time

Copies of diagnostic testing reports or testing related to the end of life care request

Physician's consult(s), regarding treatment and/or prognosis

Copies of patient's most recent lab results

Most recent chest x-ray and EKG (*If available*)

Please contact SDMC with any questions at (518) 549-0328.



Justice Center for the Protection of People with Special Needs

Declaration for End of Life Care

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460

Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

- All four declaration forms must be completed and submitted with the required supporting documentation
Please type or print in black ink
Part 13 - Declarant must sign and date where indicated
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

Part 1. Patient Information

Form fields for Patient Information: Last Name, First Name, Date of Birth, Age, Religion, Sex, Street Address, City, State, Zip, Phone, Ext, Fax, Cell.

COUNTY of Patient's Residence:

Type of Residence section with checkboxes for Intermediate Care Facility, Family Care, Individualized Residential Alternative (IRA), Nursing Home, Community Residence, Developmental Center, Assisted Living, Adult Home, Waiver, and Other Services.

Part 2a. Declarant (Required) The declarant must also sign the attestation on page 8
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.

Form fields for Declarant Information: Last Name, First Name, Title, Email Address, Agency Name, Work Mailing Address, City, State, Zip, Phone, Ext, Fax, Cell.

If the patient is hospitalized, please provide the residential contacts (residential nurse, house manager, and care coordinator/care manager) where indicated on this declaration.

Patient Last Name:

For SDMC Use Only:

The alternate declarant below 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.

Part 2b. Alternate Declarant (Required)				THIS CANNOT BE THE SAME PERSON LISTED AS THE DECLARANT IN 2a. [This could be the Agency RN, Residential Manager, Care Coordinator, or other agency staff]			
Last Name:				First Name:			
Title:				Email Address:			
Agency Name: <small>(Please avoid abbreviations)</small>							
Work Mailing Address:							
City:			State:		Zip:		
Phone: <small>Include area code</small>		Ext:	Fax: <small>Include area code</small>		Cell: <small>Include area code</small>		
Part 3. Service Providers							
Provide information relating to other service providers that are involved in the care of this patient							
Part 3a. Agency/Residential Nurse or Nursing Home Primary Nurse assigned to patient's care							
Last Name:				First Name:			
Title:				Email Address:			
Agency Name: <small>(Please avoid abbreviations)</small>							
Work Mailing Address:							
City:			State:		Zip:		
Phone: <small>Include area code</small>		Ext:	Fax: <small>Include area code</small>		Cell: <small>Include area code</small>		
Part 3b. Residential Manager Family Care Liaison or Director of Nursing Home							
Last Name:				First Name:			
Title:				Email Address:			
Agency/Residence or Name of Nursing Home:							
Work Mailing Address:							
City:			State:		Zip:		
Phone: <small>Include area code</small>		Ext:	Fax: <small>Include area code</small>		Cell: <small>Include area code</small>		

Patient Last Name:

For SDMC Use Only:

Part 3c. Care Manager | Care Coordinator | Social Worker | Service Coordinator

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Work Mailing Address:			
City:		State:	Zip:
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>

Part 3d. Hospice Contact *(If a hospice admission is anticipated, please include the hospice contact below)* **NA**

Last Name:		First Name:	
Title:		Email Address:	
Hospice Name: <small>(Please avoid abbreviations)</small>			
Work Mailing Address:			
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>

Part 3e. Hospital | Nursing Home Contact **[Preferably a case manager, social worker, or discharge planner is listed in Part 3e.]** **NA**
Provide the following information if the patient is hospitalized, or presently in a rehabilitation center or nursing home

Last Name:		First Name:	
Title:		Business Email Address:	
Hospital Nursing Home Name:			
Address of Hospital/Nursing Home:			
City:		State:	Zip:
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>
Pager: <small>Include area code</small>		Patient's Room Number:	

The Hospital or Nursing Home Contact person listed above in 3e. will be asked to assist in obtaining copies of medical information relevant to the case and also with reserving a room at the hearing location if the patient is in a hospital or nursing home.

Patient Last Name:

For SDMC Use Only:

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Part 4. Other Agencies Providing Services for the Patient *(i.e. day program, respite, senior center or care coordination)*

• Please list any other agencies providing services for the patient if not previously listed on this declaration:
(not medical clinics or service providers)

Part 5a. Legally Authorized Surrogates
Provide the following information for known surrogates:

Status of the patient's mother:	Living <i>(List below in 5b)</i>	Deceased	Whereabouts Unknown
Status of the patient's father:	Living <i>(List below in 5b)</i>	Deceased	Whereabouts Unknown

If the patient has any of these possible decision-makers, please complete 5b.

Actively involved is defined as having significant and ongoing involvement so as to have knowledge of the person's needs.

<ul style="list-style-type: none">• Health Care Proxy• Guardian• Actively Involved Spouse• Actively Involved Parent	<ul style="list-style-type: none">• Actively Involved Adult Child• Actively Involved Adult Sibling• Other Actively Involved family member
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5b. Surrogate Information:

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 an additional page if there is more than one surrogate)

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

• **Please indicate if the surrogate has an opinion on the proposed treatment or withdrawal of treatment?**

Unknown opinion	Does not wish to make the decision	Agrees	Disagrees
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• **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 the approximate dates and method of contact:**

If there are additional surrogates, please include the surrogate information on an additional page

Patient Last Name:

For SDMC Use Only:

Empty box for SDMC Use Only.

Part 6. Correspondent, Community Advocate or Family Care Provider

N/A proceed to Part 7

Correspondent means 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, by regularly visiting the patient, or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)].

Last Name:	First Name:
Email Address:	Relationship:

Address:

City:	State:	Zip:
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Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>
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Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment.

Agrees Disagrees Unknown

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

Attempts to contact the correspondent on the following date(s) were unsuccessful : Other: _____

Part 6b. Correspondents, Community Advocates or Family Care Provider(s)

Last Name:	First Name:
Email Address:	Relationship:

Address:

City:	State:	Zip:
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Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>
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• Does the correspondent have a known opinion on the proposed treatment or withdrawal of treatment?

Agrees Disagrees Unknown

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

Attempts to contact the correspondent on the following date(s) were unsuccessful: Other: _____

Patient Last Name:

For SDMC Use Only:

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Part 7. The SDMC Hearing
If the patient is hospitalized, the SDMC hearing will be held at the hospital. At least one SDMC panel member will visit the patient to observe and interview the patient prior to the hearing, as required by regulation.
The patient is presently hospitalized and will need to be visited by a panel member prior to the hearing:
The patient is not presently hospitalized and the hearing may be held at the patient's home:

Part 8. Supporting Documentation Review [REQUIRED]	
<ul style="list-style-type: none">As the Declarant, I have read the Certification on Capacity for End of Life Care (SDMC Form 310) stating that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Consulting Physician or NYS Licensed Psychologist.	YES <i>I have reviewed the Capacity Certification</i>
<ul style="list-style-type: none">As the Declarant, I have read the Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B) describing the patient's medical condition, the risks, benefits and alternative(s) to the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Concurring Physician.	YES <i>I have reviewed the Medical Certification</i>

Part 9a. Proposed Treatment to be Withheld and/or Withdrawn
<ul style="list-style-type: none">The proposed withholding and withdrawal of life sustaining treatment(s) is/are as follows: <i>See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B)</i>

Part 9b. Artificial Nutrition and/or Hydration:		
<ul style="list-style-type: none">Has the physician requested to withhold/withdraw life-sustaining artificially provided nutrition or hydration for the patient?	YES	NO

Part 10. Hospice
<ul style="list-style-type: none">Is a Hospice admission anticipated? Yes No <i>If the patient has been evaluated by Hospice already, please attach the evaluation.</i>

Part 11. Additional Information <i>[Required by the Health Care Decisions Act, SCPA Article 17-A, § 1750-b]</i>
<ul style="list-style-type: none">List the title of the person that explained the proposed treatment decision to the patient:Describe the efforts to determine the moral and religious beliefs of the patient and the patient's reaction when the proposed withholding/withdrawal of life-sustaining treatment(s) was/were explained:

Patient Last Name:

For SDMC Use Only:

Part 11. Additional Information, continued

- Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment.
- Based on your personal knowledge of this patient, explain in your own words why you believe the proposed treatment decision(s) is/are in the best interest of the patient.

Part 12. Communication Needs

Please check all that apply

Does the patient understand English? Yes No

Does the patient speak English as his/her primary language? Yes No

If the patient is a non-English speaker, please indicate the language that is spoken or understood:

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

Patient is nonverbal or unable to verbally communicate (due to medical condition such as heavy sedation, unconsciousness, or intubation)

Patient is able to point or gesture to make needs known _____

The patient's expressive skills are limited.

*If YES, please indicate type (foreign language, sign language, other):

Is the patient able to verbally communicate his/her needs? Yes No Comments:

Part 13. Attestation by the Declarant

This request is based on the patient's qualifying medical condition other than intellectual or developmental disability, with recognition that a person with an intellectual or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without intellectual or developmental disabilities and without any financial considerations that affect the health care provider or any other party.

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

Signature of Declarant: _____

Date: / /
 MM DD YEAR

Declarant is listed on page 1, Part 2a

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

Please submit this declaration together with the following:

- Certification on Capacity for End of Life Care (SDMC Form 310); and
- Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B); and
- Related Medical Information for End of Life Care (SDMC Form 330); and
- Supplemental medical information to support the declaration for an end of life care decision.

REMINDER:

- The OPWDD MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed after the SDMC End of Life hearing- not before the hearing
- Notifications per SCPA § 1750-b are required after the SDMC hearing



Justice Center for the Protection of People with Special Needs

Certification on Capacity for End of Life Care

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 2 & 3 - An attending physician, in consultation with another physician or a NYS licensed psychologist must complete this section
Part 4 - Either the attending physician or the consulting physician/or NYS licensed psychologist must meet the additional requirements for experience with ID/DD individuals (see page 3)

For SDMC Use Only:

Part 1. Patient Information
Last Name: First Name:
Agency where the Patient Resides or Receives Services:
Phone: Ext: Fax:
Part 2. Attending Physician
Last Name: First Name:
Email Address: Professional License Number:
Business Address:
City: State: Zip:
Phone: Ext: Fax: Cell:
Date of examination of patient: MM / DD / YEAR
a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability:
b. The extent and probable duration of this intellectual disability or incapacity is:
c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.)
I am an attending physician for the patient and the information and statements which I have provided are accurate and truthful to the best of my knowledge.
Signature of Attending Physician: Date: MM / DD / YEAR

Patient Last Name:

For SDMC Use Only:

Part 3. Consulting Physician or NYS Licensed Psychologist [This cannot be the same physician identified in Part 2.]

Last Name: First Name:

Email Address: Professional License Number:

Business Address:

City: State: Zip:

Phone: Ext: Fax: Cell:
Include area code

Check all that apply:
 Consulting Physician NYS Licensed Psychologist Date of Examination of Patient:

a. I find to a reasonable degree of medical certainty that the patient lacks capacity to make health care decisions. The patient has been diagnosed with the following intellectual disability:

b. The extent and probable duration of this intellectual disability or incapacity is:

c. If available, list any recent psychological tests, results and/or the patient's IQ or developmental age. (Testing is not necessary to complete this form.)

d. Summarize the clinical evaluation, including the patient's reaction when you explained the proposed withholding/withdrawal of life sustaining treatment(s) that validates your opinion regarding the patient's decision making ability.

It is my clinical opinion that the patient does not have the capacity to make an informed decision regarding the proposed withholding/withdrawal of life sustaining treatment(s). The information and statements which I have provided are accurate and truthful to the best of my knowledge.

Date: / /

Signature of Physician | NYS Licensed Psychologist:

MM DD YEAR

Patient Last Name:

For SDMC Use Only:

Please contact SDMC if you are unable to access a physician or NYS licensed psychologist who meets the required qualification in Part 4: 518 549-0328

Part 4. Attestation

The attending physician completing Part 2 of this form or the consulting physician/psychologist completing Part 3 must attest to meeting at least one of the following criteria:

Print

Last Name:

Print

First Name:

Check all that apply:

- Employed by a Developmental Disability Services Office as defined in Mental Hygiene Law § 13.17
- Have been employed for a minimum of two years to render care and services in a Program operated, licensed or authorized by the Office for Persons with Developmental Disabilities (OPWDD).
- Has been approved by the Commissioner of the Office for Persons with Developmental Disabilities (OPWDD)

Date:

/ /

Signature of Physician | NYS Licensed Psychologist:

MM

DD

YEAR



Attending Physician and Concurring Physician Certification for End of Life Care

401 State Street
Schenectady, NY 12305
SDMC Phone: 518-549-0328

INSTRUCTIONS:

- Please complete the fillable form below, print and sign in black ink. All parts of this form must be completed and returned to the declarant to be submitted together with other declaration forms.
Part 4- Attending and concurring physicians must both sign where indicated
Part 10- Attending and concurring physicians must both sign the attestation

For SDMC Use Only:

Part 1. Is an Expedited Review necessary?

YES NO

The withholding or withdrawing of life sustaining treatment is requested as soon as possible

If YES, you must state the medical condition to support the 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 3a. Attending Physician

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:
Include area code

Ext:

Cell:
Include area code

Fax:
Include area code

Part 3b. Concurring Physician

Last Name:

First Name:

Professional License Number:

Business Address:

City:

State:

Zip:

Phone:
Include area code

Ext:

Cell:
Include area code

Fax:
Include area code

Patient Last Name:

For SDMC Use Only:

Parts 5-8 are completed by the Attending Physician and reviewed by the Concurring Physician

Part 9 is completed by the Concurring Physician

The Concurring Physician may note additional comments and opinions regarding the life-sustaining treatment and/or the burden of treatment for this patient.

Part 5. Attending and Concurring Physician Request to Withhold/Withdraw Life-Sustaining Treatment:

5a. End of Life Care Treatment Plan

Based on the patient's medical condition, I request consent for the following Medical Orders for Life-Sustaining Treatment:

DNR- withhold CPR

Please check only the End of Life treatment decisions requested

DNI- withhold mechanical ventilation or intubation

Withdraw Antibiotics

Withdraw Mechanical Ventilation

Withhold Antibiotics

Withhold Future Hospitalizations unless pain or severe symptoms cannot otherwise be controlled.

Antibiotics will be used only to meet the patient's overall treatment goal of providing comfort.

Withdraw Vasopressors

Withhold Vasopressors

- PLEASE SPECIFY ANY OTHER LIFE-SUSTAINING TREATMENT(S) TO BE WITHHELD OR WITHDRAWN:
(i.e. withhold/withdraw dialysis; withhold blood transfusions)

ARTIFICIAL NUTRITION AND HYDRATION

Withhold IV Fluids

No Feeding Tube (Withhold placement of a feeding tube for artificial nutrition and hydration)

Withdraw IV Fluids

Withhold/Withdraw Artificial Nutrition and/or Hydration

⇨ If artificial nutrition and/or hydration is to be withheld/withdrawn, the attending physician must find to a reasonable degree of medical certainty that one of the two following conditions are met: ⇩

There is no hope of maintaining life OR

The artificially provided nutrition or hydration would impose an extraordinary burden on the patient.

If a decision to withhold/withdraw life-sustaining artificial nutrition and/or hydration is checked above, the physician must also document the EXTRAORDINARY BURDEN of providing artificial hydration or nutrition to the patient.

- Please state the Extraordinary Burden of Providing Artificial Nutrition and/or Hydration to the patient:
[Required only if a decision to withhold/withdraw artificially provided nutrition/hydration is requested]

5b. I find that the life-sustaining treatment(s) indicated above would impose an EXTRAORDINARY BURDEN on the patient in light of the patient's medical condition. Please state the EXTRAORDINARY BURDEN the life-sustaining treatments pose to the patient. *If available, list any diagnostic tests or medical information that supports your findings.* [REQUIRED]

Patient Last Name:

For SDMC Use Only:

Parts 5-8 are completed by the Attending Physician and reviewed by the Concurring Physician

Part 9 is completed by the Concurring Physician

The Concurring Physician may note additional comments and opinions regarding the life-sustaining treatment and/or the burden of treatment for this patient.

• COMFORT CARE / HOSPICE SERVICES

Provide Comfort Care with Hospice Services

Provide Comfort Care

(Comfort Care is defined as medical care and treatment provided with the primary goal of relieving pain, symptoms, and reducing suffering)

PLEASE NOTE:

When Comfort Care is included on an SDMC consent, it does NOT authorize any additional withdrawal or withholding of life sustaining treatment which is not specifically included in the SDMC decision. Any life sustaining treatment to be withheld or withdrawn must be specified on the SDMC consent.

Part 6. Expected Outcome of Continued Life-Sustaining Treatment

[REQUIRED]

Describe the expected or likely outcome of continued life-sustaining treatment(s) provided for this patient notwithstanding the patient's intellectual or developmental disability.

Please include the potential restoration of functioning or recovery that would be likely if life-sustaining treatment were to be continued indefinitely.

Part 7. Alternatives

[REQUIRED]

- Is there an alternate procedure available to this patient that will preserve, improve or restore the patient's health?

YES

NO

If **YES**, please state the procedure:

Please explain the rejection of this alternate procedure:

Patient Last Name:

For SDMC Use Only:

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Part 4. Exams and Tests		
a. Date of most recent annual physical examination or the hospital admission and history note. Please include a copy of the most recent physical.	Date: _____	
b. List any abnormal findings from exams and tests:		<input type="checkbox"/> N/A
c. Date of most recent EKG. Include a copy.	Date: _____	<input type="checkbox"/> N/A
d. Date of most recent chest x-ray. Include a copy.	Date: _____	<input type="checkbox"/> N/A
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):		<input type="checkbox"/> N/A
b. List any major illness, surgery, and/or hospitalizations in the last year:		<input type="checkbox"/> N/A
c. List any other known physical condition or medical diagnosis:		
Part 6. Prior SDMC Review		
Has the patient been reviewed by SDMC previously?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown

Patient Last Name:

For SDMC Use Only:

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Part 7. Form Submitter's Contact Information

Last Name:		First Name:	
Email Address:		Title:	
Agency Name: <small>(Please avoid abbreviations)</small>			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code</small>	Ext:	Fax: <small>Include area code</small>	Cell: <small>Include area code</small>

Part 8. Attestation

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

Signature of person completing this form: _____ Date: _____ / _____ / _____
MM DD YEAR

PLEASE REMEMBER TO ATTACH

Documentation related to the requested End of Life Care:

- Consults
- Annual Physical Exam
- Progress notes
- Results of diagnostic tests

REMINDER:

The OPWDD MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed and all legally required notifications must be made before an SDMC End of Life decision may take effect.