NEW YORK STATE OF OPPORTUNITY. | 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: (Please avoid abbreviations)			
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: Include area code	Ext:	Fax:	Cell:
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)

_____

Signature of Physician | NYS Licensed Psychologist:

Date: ____ / ____ / ____

MM DD YEAR