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

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?

The withholding or withdrawing of life sustaining treatment is requested as soon as possible ☐ **YES** ☐ **NO**

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:

Part 4. Attending and Concurring Physician Findings **[REQUIRED]**

As a result of my examination, I have determined, to a reasonable degree of medical certainty, that the patient has been diagnosed with the following medical conditions:

(Check all that apply; at least one box must be checked)

☐ A terminal condition where the patient has an illness or injury from which there is no recovery and which reasonably can be expected to cause death within one year *(briefly describe)*; or

☐ Permanent unconsciousness; or

☐ A medical condition, other than intellectual or developmental disability which requires life-sustaining treatment, is irreversible, and which will continue indefinitely. *(Briefly describe)*

Signature of Attending Physician:

_____

Date: ___/___/___ (MM / DD / YEAR)

Date of Review or Examination of Patient: ___/___/___ (MM / DD / YEAR)

Signature of Concurring Physician:

_____

Date: ___/___/___ (MM / DD / YEAR)

Date of Review or Examination of Patient: ___/___/___ (MM / DD / YEAR)

Please include copies of progress notes, medical records, consultation, or other relevant reports to support the patient's medical condition.

The Attending Physician and Concurring Physician must sign and date above.

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:

Please check only the End of Life treatment decisions requested

- ☐ **DNR-** withhold CPR
- ☐ **DNI**- withhold mechanical ventilation or intubation
- ☐ Withdraw Mechanical Ventilation
- ☐ Withhold Future Hospitalizations unless pain or severe symptoms cannot otherwise be controlled.
- ☐ Withdraw Vasopressors ☐ Withhold Vasopressors
- ☐ Withdraw Antibiotics
- ☐ Withhold Antibiotics
- ☐ Antibiotics will be used only to meet the patient's overall treatment goal of providing comfort.

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WITHDRAWN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

<u>ARTIFICIAL NUTRITION AND HYDRATION</u>

- ☐ 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:

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.

For SDMC Use Only:

- **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:

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 8. Justification by Attending Physician **[REQUIRED]**

In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

Part 9. Justification by Concurring Physician **[REQUIRED]**

In my clinical opinion, the proposed withholding or withdrawal of treatment is in the best interest of the patient for the following reasons:

Part 10. Attestation
(Attending Physician and Concurring Physician must sign and date the attestation) **[REQUIRED]**

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

Signature of Attending Physician: _____ Date: ___/___/___ (MM / DD / YEAR)

Signature of Concurring Physician: _____ Date: ___/___/___ (MM / DD / YEAR)

The Attending Physician and Concurring Physician must both sign and date above.

- The OPWDD MOLST Checklist for Individuals with Developmental Disabilities must be completed after the SDMC End of Life Hearing.
- The Attending Physician is responsible for making the appropriate notifications of the end of life care decision following the hearing.