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

Related Medical Information for End of Life Care

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

INSTRUCTIONS:

- Please complete the 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 8** – The person submitting the form must complete, sign and date where indicated
- **Please remember to attach:** consults, progress notes, latest annual physical exam, results of diagnostic tests and other related documentation
- **Please call SDMC at (518) 549-0328 to confirm receipt**

For SDMC Use Only:

Part 1. Patient Information

Last Name:	First Name:

Part 2. Current Medications

a. Provide information pertaining to the patient's current medications. *(may attach a list of medications)*

Current medication	Dosage	Frequency	Mode of Intake

b. List any drugs requiring frequent blood level monitoring. Include a copy of the most recent lab work.

Part 3. Allergies

Any known allergies?

Patient Last Name:

For SDMC Use Only:

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: ☐ **N/A**

c. Date of most recent EKG. Include a copy. ☐ **N/A**

Date: _____

d. Date of most recent chest x-ray. Include a copy. ☐ **N/A**

Date: _____

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): ☐ **N/A**

b. List any major illness, surgery, and/or hospitalizations in the last year: ☐ **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? ☐ Yes ☐ No ☐ Unknown

Patient Last Name:

For SDMC Use Only:

Part 7. Form Submitter's Contact Information			
Last Name:		First Name:	
Email Address:		Title:	
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

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
- Progress notes
- Annual Physical Exam
- 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.