



Mount Sinai Health System
New York, NY

Family Health Care Decisions Act (FHCDA) Form 3

Adult Patient Without a Surrogate: Authorization for Major Medical Treatment¹

This form must be filled out with the approval of the Primary Attending Physician². _____
Print name of primary attending

DO NOT use this form if the patient has appointed a health care proxy and the agent is available.

DO NOT use this form if the patient lacks capacity due to mental illness or developmental disability. Instead, contact the Office of the General Counsel.

DO NOT use this form if the treatment decision concerns withholding or withdrawing life-sustaining treatment. Instead, use Form 5.

I. Initial Determination of Incapacity (SKIP AND PROCEED TO STEP II if a court has already determined that the patient lacks capacity to make health care decisions).

Two Clinicians (the Primary Attending Physician, other attending physicians, nurse practitioners, physician assistants, or licensed House Staff) must make the determination of incapacity **as long as the Primary Attending Physician concurs.**

I have determined to a reasonable degree of medical certainty that the patient lacks capacity to make the decision described as follows: _____

I found that the cause and extent of the patient's incapacity are _____

and the likelihood that the patient will regain decision-making capacity is _____

Clinician³ (print name)

Signature

Time

Date

NOTE: For all treatments not provided at or about the time of the initial determination of incapacity, a Clinician³ must confirm continuing incapacity. See Step V.

¹ The FHCDA defines major medical treatment as: any treatment, service or procedure to diagnose or treat the patient's physical or mental condition: (i) where a general anesthetic is used; or (ii) which involves any significant risk; or (iii) which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or (iv) which involves the use of physical restraints as defined in New York State Department of Health regulations, except in an emergency; or (v) which involves the use of psychoactive medications, except when provided as part of post-operative care or in response to an acute illness and treatment is reasonably expected to be administered over a period of 48 hours or less, or when provided in an emergency.

² The Primary Attending Physician is an attending physician who is a member of the Mount Sinai Medical Staff and is directing the patient's care at the time the relevant determination or decision is being made and may also include a covering attending physician directing the patient's care when the primary Primary Attending Physician is unavailable.

³ The Primary Attending Physician and with the Primary Attending Physician's approval, another physician, nurse practitioner, physician's assistant or licensed house staff.

II. Patient's Prior Decisions

In some cases, the patient may have made decisions about health care before losing capacity that are relevant to the decision now under consideration. If the patient's prior decisions are known and relevant to the decision being contemplated at this time, the Primary Attending Physician shall rely on the patient's prior decision in making treatment decisions. The Primary Attending Physician must document these prior decisions in the medical record. (See Form 5 regarding documenting prior decisions to withhold or withdraw life sustaining treatment.)

III. Document Lack of Surrogate

I, or someone acting on my behalf, despite reasonable and diligent efforts, was unable to identify a Surrogate for the patient, who was reasonably available, willing, and competent to act.

Clinician³ (print name)

Signature

Time

Date

IV. Notify the Patient⁴ (Check one)

- The patient has been informed that he or she has been determined to lack capacity, **AND** the patient has been informed of the proposed major medical treatment, **OR**
- The patient has NOT been informed of the above because there is no indication that the patient can comprehend the information.

Clinician² (print name)

Signature

Time

Date

Preferred Language Interpreter Name or Number

Signature

Date

Time

Patient refused interpreter
(check box if applicable)

Telephone/Video Consent (Check box if applicable), Patient/Guardian/Representative/Interpreter signature not required.**

NOTE: If the patient objects to the determination of incapacity or health care decision, the patient's wishes prevail unless there is a medical emergency or a court order (See FHCDA Policy [MSHS 206]).

⁴ If the patient was transferred from a mental hygiene facility, notice must also be given to the director of the facility and to Mental Hygiene Legal Services.

