



Mount
Sinai
Beth Israel



Mount
Sinai
Brooklyn



530

MSMRN:

V:

Sex:

DOB:



**FAMILY HEALTH CARE DECISIONS ACT
FORM 3**

**Adult Patient Without Capacity Without a Surrogate:
Authorization for Major Medical Treatment¹**

DO NOT USE THIS FORM IF THE PATIENT HAS APPOINTED A HEALTH CARE PROXY AND THE AGENT IS AVAILABLE AND WILLING TO SERVE.

I. Determination of Incapacity

The Family Health Care Decisions Act does not apply to all patients who lack decision making capacity because of mental illness, mental retardation or developmental disability. (See Policy No. 2003A)²

Initial Determination of Incapacity

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 _____.

Attending Physician

Signature

Date/Time

II. Patient's Prior Decisions About Major Medical Treatment

In some cases, the patient may have made decisions about health care prior to losing capacity that are relevant to the decision under consideration at this time. Prior decisions may include specific consents for treatment or decisions to forgo specific interventions. If the patient's prior decisions are known and relevant to the decision being contemplated at this time, the attending physician shall rely on the patient's prior decision(s). The attending physician must document any prior decisions in the medical record.

FOR THOSE PRIOR DECISIONS TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENT, INCLUDING DNR, USE FHCD A FORM 5.

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.

Attending Physician

Signature

Date/Time

IV. Notify the Patient³

(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.

Attending Physician or designee

Title - MD, PA, NP

Signature

Date/Time

If the patient objects to the determination of incapacity or to the selection of the surrogate or to a health care decision made by the surrogate, the patient's wishes prevail.⁴

¹ The FHCD A defines major medical treatment as any treatment, service or procedure to diagnose or treat the patient's physical or mental condition: (i) where 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 If the attending physician determines that a patient lacks capacity due to mental illness, mental retardation, or developmental disability, then a second physician with certain qualifications must make the determination of incapacity (if the attending physician does not have these qualifications).

³ 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.

⁴ The patient's decision prevails unless there is a court order to the contrary or another legal basis exists to override the patient's objection(s).



V. If no Surrogate has been identified, the decision to provide major medical treatment will be made as follows:

1. Document the proposed major medical treatment _____

MSMRN:
V: Sex: DOB:



2. (Check as applicable)

- a. (i) _____ I am authorizing this decision in accordance with the patient's prior wishes, expressed orally or in writing, including the patient's religious and moral beliefs; **OR**
- (ii) _____ I do not know and cannot with reasonable diligence find out the patient's wishes and therefore I am authorizing this decision because it is in the patient's best interests.
- b. My decision is patient-centered (i.e., it is based on the patient's wishes and interests and not my own or someone else's wishes or interests or the financial interests of the hospital or any health care professional). I believe it is consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible, and to the extent they are known to me.
- c. I have consulted with hospital staff directly responsible for the patient's care and recommend that the treatment described above be provided to the patient.

Name of Attending Physician Signature Date/Time

VI. Concurring Opinion by Another Physician Designated by the Hospital⁵

I concur with the determination of the Attending Physician that the treatment proposed is appropriate because

Name of Concurring Physician Signature Date/Time

VII. Confirmation of Continued Lack of Capacity⁶

For major medical treatment decisions not carried out at or about the time the determination of incapacity was made, a confirmation is required.

I have confirmed that the patient continues to lack decision-making capacity.

Name of Attending Signature Date/Time

VIII. Ethics Process

If there are any concerns of an ethical nature, please consult the Ethic Consultation Policy (No. 2034).

IX. Attending Physician's Documentation

The Attending physician must document in the medical record the procedure to be performed.

5 The concurring physician must not be a member of the team responsible for the care of the patient and must independently determine that he or she concurs with the Attending's treatment recommendation.
6 The confirmation of incapacity may be made by the attending physician or another attending.

THIS FORM MUST BE PLACED IN THE MEDICAL RECORD.

