

Mount Sinai Health System New York, NY

Family Health Care Decisions Act (FHCDA) Form 1

Adult Patient: Enabling the Surrogate to Consent to Treatment

This form must be filled out with the approval of the Primary Attending Physician¹.

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 for a patient who 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 4.

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).

I have determined to a reasonable degree of medical certainty that the patient lacks capacity to make treatment decisions. 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

Clinician ² (print name)	Signature	Time	Date

NOTE: For all treatments not provided at or about the time of the initial determination of incapacity, a Clinician² must confirm continuing incapacity. See Step V.

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. 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 Primary Attending Physician shall rely on the patient's prior decisions in making treatment decisions. The Primary Attending Physician must document these prior decisions in the medical record and communicate those decisions to the Surrogate identified below in Step III. For prior decisions to withhold or withdraw life-sustaining treatment, including DNR, use Form 4 where a Surrogate exists and Form 5 where no Surrogate exists.

¹ 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 Attending Physician is unavailable.

² The Primary Attending Physician and with the Primary Attending Physician's approval, another physician, nurse practitioner, physician's assistant or licensed house staff.

III. Identify and Inform the Surrogate

a. Identifying the Surrogate

The Surrogate is a person from the following list who is from the class that is highest in priority and who is reasonably available, willing, and competent to act. (Check one and identify below)

- A guardian authorized to decide about health care pursuant to Mental Health Hygiene Law Article 81
- □ The spouse, if not legally separated from the patient, or the Domestic Partner³
- □ A son or daughter eighteen years of age or older
- □ A parent
- □ A brother or sister eighteen years of age or older
- □ A Close Friend⁴

Name of Surrogate		Relationship to Patient
Mobile phone number	Home phone number	Email address

b. Informing the Surrogate

□ I have informed the Surrogate (or at least one other person from the highest class available on the Surrogate list) that the patient has been determined to lack capacity and that the Surrogate will make health care decisions for the patient.

Clinician ² (print name)	Signature	Time		Date
Preferred Language Interpreter Name or Number	Signature	Date	Time	Surrogate refused interpreter (check box if applicable)

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

IV. Notify the Patient⁴ (Check one)

a. Identifying the Surrogate

- □ The patient has been informed that he or she has been determined to lack capacity and that a Surrogate has been identified to make health care decision(s) for him; **OR**
- □ The patient has NOT been informed of the above, because there is no indication that the patient can comprehend the information.

Clinician ² (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, choice of surrogate, or health care decision, the patient's wishes prevail unless there is a medical emergency or a court order (See FHCDA Policy [MSHS 206]).

³ If the Surrogate is a Domestic Partner, use Form 2 to document their status.

⁴ If the Surrogate is a Close Friend, use Form 2 to document their status.

⁵ 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.

V. Confirmation of Continued Incapacity

For all subsequent treatments not provided at or about the time of the initial determination of incapacity, ongoing confirmation of continued incapacity is required.

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

Clinician ² (print name)	Signature	Time	Date
I have confirmed that the patie	nt continues to lack decision-making	capacity.	
Clinician ² (print name)	Signature	Time	Date
I have confirmed that the patie	nt continues to lack decision-making	capacity.	

VI. Ethics Process

Should an ethics consultation be helpful, please contact the system operator at 212-241-6500 (See hospital's Ethics Committee policy).

VII. Surrogate's decision(s) shall be entered in the medical record.