

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 a	pproval of the Primary Atte	ending Physician².	of primary attending
DO NOT use this form if the patient h	as appointed a health care	e proxy and the agent is av	of primary attending vailable.
DO NOT use this form if the patient la Instead, contact the Office of the Ge		al illness or developmenta	l disability.
DO NOT use this form if the treatmer treatment. Instead, use Form 5.	nt decision concerns withh	nolding or withdrawing life	-sustaining
I. Initial Determination of Incap that the patient lacks capacity to make		D TO STEP II if a court has al	lready determined
Two Clinicians (the Primary Attending Flicensed House Staff) must make the de			•
I have determined to a reasonable de	gree of medical certainty tha	at the patient lacks capacity t	o make the decision
described as follows:			
I found that the cause and extent of the			
and the likelihood that the patient will	acity is		
Clinician ³ (print name)	Signature	Time	 Date
NOTE: For all treatments not provide must confirm continuing incapacity.		nitial determination of incapa	acity, a Clinician³

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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	Surrog	ate
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Clir	nician³ (print name)	signature	Time	Date
/. N	otify the Patient ⁴ (Check one)			
	The patient has been informed that he been informed of the proposed major		ed to lack capacity, AND	the patient has
	The patient has NOT been informed comprehend the information.	of the above because there	is no indication that the	patient can
C	linician² (print name)	Signature	Time	 Date

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 $^{^4}$ 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.

V. Document Decision to Provide Major Medical Treatment

Clinician³ (print name)

а.	De	Decision The proposed major medical treatment Criteria Used by Primary Attending Physician								
	The									
Э.	Cri									
		I am authorizing this decision in accincluding the patient's religious and	•	nt's prior wishes, expr	essed ora	lly or in writing,				
		☐ 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;								
		AND								
		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;								
		AND								
		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.								
C	Clinici	an² (print name)	Signature	Time		Date				
						Surrogate refuse				
F	refer	rred Language Interpreter Name or Number	Signature	 Date	Time	interpreter (check box if applicable)				
	T	elephone/Video Consent (Check box if	applicable), Patient/Gua	dian/Representative**/	Interpreter	signature not require				
).	Со	ncurring Opinion								
	Ico	oncur with the determination of the C	linician ³ that the treatm	ent proposed is appr	opriate be	cause				
						· · · · · · · · · · · · · · · · · · ·				

Time

Date

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Signature

VI. Confirmation of Continued Lack of Capacity

confirmation of continued inca	pacity is required.			
I have confirmed that the patie	nt continues to lack decision-making	capacity.		
Clinician ³ (print name)	Signature	Time	Date	
I have confirmed that the patie	nt continues to lack decision-making	capacity.		
Clinician³ (print name)	 Signature		Date	
,	nt continues to lack decision-making		Date	
mave commined that the patie				
	The continues to lack decision making	capacity.		
	The continues to lack decision making	сарасну.		

For all subsequent treatments not provided at or about the time of the initial determination of incapacity, ongoing

VII. Ethics Process

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

VIII. Clinician's Order

The Clinician³ **shall enter** the order to withhold or withdraw treatment in the medical record consistent with the Surrogate's decision **as long as the Primary Attending Physician concurs.**

THIS FORM MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

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