

Patient Name _____

Medical Record No _____

PHYSICIAN CERTIFICATIONS RELATED TO MEDICAL
CONDITION, DECISION MAKING, AND TREATMENT LIMITATIONS

PART 1: IDENTIFYING INFORMATION

- Patient: I am certifying information about _____
- Certifying practitioner (check all that apply): I am () the attending physician/() the medical director or another certifying practitioner/() a neurologist, neurosurgeon, or other physician with special expertise in evaluating cognitive functioning required for diagnosing a persistent vegetative state.
- Time frame: () The following certifications are made within 2 hours of examining the individual.

PART 2: CERTIFICATIONS

a) Certification of General Status

Based on my evaluation, I hereby certify that this individual (select one, if applicable):

- ☐ Is in an **end-stage condition** based on *all of the following*:
- has an advanced, progressive, irreversible condition caused by injury, disease, or illness AND
 - has severe and permanent deterioration indicated by incompetency and complete physical dependency AND
 - to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.
- ☐ is in a **persistent vegetative state** based on *all of the following*:
- injury, disease, or illness have resulted in a loss of consciousness AND
 - the individual exhibits no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles and nerves for low level conditioned response AND
 - after passage of a medically appropriate period of time, it has been or can be determined, to a reasonable degree of medical certainty that there can be no recovery.
- ☐ is in a **terminal condition** caused by injury, disease, or illness based on *both of the following*:
- to a reasonable degree of medical certainty, death is imminent AND
 - despite the application of life-sustaining treatments, there can be no recovery.

b) Certification Regarding Medical Ineffectiveness

- ☐ I hereby certify that, to a reasonable degree of medical certainty, the following treatment(s), which under generally accepted medical practices are life-sustaining in nature, would not prevent or reduce the deterioration of the individual's health or prevent his or her impending death (list treatments):
- () CPR () Mechanical Ventilation or Respiration () Hospitalization () Antibiotics () Blood Products
() Medical Tests () Artificial Hydration () Artificial Nutrition () Other _____

I have informed the following individual(s) of my determination that the treatments designated above would be medically ineffective: () the affected individual () the individual's Agent, guardian, or surrogate.

c) Certification Regarding Decision Making Capacity

- 1) **Level of decision making capacity.** Based on my evaluation, I hereby certify that this individual (check one):
- () has adequate decision making capacity (including decisions about life-sustaining treatments)
- () lacks adequate decision making capacity (including decisions about life-sustaining treatments)

- 2) **Diagnosis or reason for incapacity:** ☐ Dementia ☐ Stroke/CVA ☐ Brain injury ☐ Delirium
☐ Other _____

Signed _____, M.D.

Date _____