ETHICS COMMITTEE CONSULTATION—REQUEST

Completion of this form is the initial step to facilitating a consultation by the Ethics Committee. A consultation may be requested when serious ethical concerns are identified by the patient, family member, person with a significant relationship to the patient; a nurse, physician or any other clinical hospital employee.

Name of Patient:______________________________ Date: __________ Time: __________

Name of Requestor:__________________________ Phone Number:____________________

Relationship to Patient:________________________

Does the requestor want their name to remain confidential?  Y  N

Is the attending Provider aware of this request for an ethics consult?  Y  N

If not, why not?_______________________________________________________________

Is the Primary Care Provider aware of this request for an ethics consult?  Y  N

If not, why not?_______________________________________________________________

1. Please clearly state the issue you want addressed:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

2. Describe in further detail your concerns about the issue:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

This form should be submitted to one of the following who will then forward to the Chairperson of the Ethics Committee:

- Spiritual Care Coordinator
- Department Director/Manager
- House Supervisor
- Risk Manager