

**ETHICS CONSULTATION FORM**

Date:

Patient Name:

Person Requesting Consult:

Title/Department/Phone#:

Current Attending Physician:

Outpatient Primary Care Provider:

Patient Location/Department:

Consultation/ethical questions for Committee (What is the specific ethics question ethical dilemma, or proposed course of action/intervention you would like the Ethics Committee to address?):

Patient information:

Age\_\_\_\_\_\_ Race\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_ Religion\_\_\_\_\_\_ Other Identifiers: \_\_\_\_\_\_\_

Ethnicity (circle one) Option 1: Hispanic or Latino, Option 2: Not Hispanic or Latino

Brief medical history, pertinent diagnosis and condition at time of consult:

1. **Capacity**
2. Does the patient currently have decisional capacity? Yes/No
3. If patient lacks decision making capacity, please provide details and explain if he/she is likely to regain capacity.

1. **Directives**
2. Does patient have declared wishes (Yes/No)?
3. If known, what are they?
4. Attach a copy of any relevant information.
5. **Proxy/Surrogate**
6. Does patient have a health care proxy/surrogate or guardian (Yes/ No)? Please circle applicable agent.
7. How can the proxy/surrogate/guardian be reached?
8. What’s the health care agent’s understanding of the patient’s wishes?

1. **Family**
2. Does the health care agent’s medical decision conflict with the patient’s family or alternate surrogates

(Yes/No).

1. If so, please identify relationship and expressed known wishes.

Relationship and wishes:

 Relationship and wishes:

1. What are the **recommendations** of providers? (MDs, RNs, MSWs, etc.?):

Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a conflict between/among provider recommendations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please describe the **issues** that concern you about the case? For example: safety concerns, decision making ability concerns, end of life care concerns, best interest of the patient, conflicts, provider-patient relationship issues, disagreement on treatment options, discharge planning or other issues.

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 Print name: Date: ***For Ethics Committee:***

1. Attendees for consult (circle all that apply):

Patient Family Friend Attending Physician

Physician Nursing Social Work In-House Attorney Chaplain

Staff Committee Members (how many: \_\_\_)

1. Restatement of the ethical issues of the consult:
2. Legal Issues of the consult:

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1. Meeting Conclusion and Ethics Committee Final Recommendations:

1. Does the case involve:
2. Withholding or withdrawing life sustaining treatment (Yes/ No)?
3. Withdrawing nutrients/hydration from a patient (Yes/ No)?
4. Admitting the patient to hospice (Yes/ No)?
5. Is this a binding determination (i.e. involves withholding/withdrawing LST (not DNR) for CCC resident per PHL§ 2994-d(5)(6) or decisions regarding emancipated minor patients and life sustaining treatment per PHL§ 2994(e) (Yes/ No)?

Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Committee Chair Signature