Volunteer Bereavement Contact Record

Contact Made With: _____ Relationship: _____

Patient Name: _____ Patient #:_____

Date of Contact: _____ Time:_____ AM / PM Length of Contact:_____ Travel Time:_____ Miles Driven:_____

TYPE OF CONTACT

☐ Home Visit
☐ Office Visit
☐ Support Group
☐ Funeral/Visitation
☐ Phone Call
☐ Card/Letter
☐ Other

PROBLEMS OBSERVED

☐ Suicidal
☐ Depressed
☐ Activity Level/Energy Level
☐ Anxiety/Anxious
☐ Expression of Feelings
☐ Detachment/Isolation
☐ Memory Problems
☐ Confused
☐ Appetite/Weight Loss
☐ Despair
☐ Sleep Disturbance
☐ Health Problems
☐ Substance Abuse
☐ Poor Support System
☐ Appearance
☐ Spiritual Concerns
☐ Adjustment to Loss
☐ Needs & Resources
☐ Ability to Cope
☐ Home Appearance
☐ Anger
☐ Guilt
☐ Family Conflict

PLAN OF CARE

☐ Contact Hospice Office
☐ Request Bereavement Coordinator to Contact
☐ Continue to Follow _____
☐ Referral
☐ Closure Made
☐ Increase Frequency of Contacts _____
☐ Decrease Frequency of Contacts _____

COMMENTS

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Signature: _____ **Title:** _____

CONTACT RECORDS MUST BE SUBMITTED WITHIN 1 WEEK (7 WORKING DAYS) AFTER CONTACT.