Patient Volunteer Contact Record

Patient Name: _____ Patient #: _____

Date of Contact: _____ Time:_____AM / PM Length of Contact: _____ Travel Time:_____Miles Driven: _____

TYPE OF VISIT

- ☐ Home Visit
- ☐ Hospital Visit
- ☐ Nursing Home Visit
- ☐ Phone Call
- ☐ Card
- ☐ Other
- ☐ Errand
- ☐ Bereavement
- ☐ Visit Declined by Patient/Family

SPECIFIC AREA OF SUPPORT

- ☐ Sat with patient to provide respite care
- ☐ Emotional support to patient/family
- ☐ Meal Preparation
- ☐ Other _____
- ☐ Ramp
- ☐ Household Chores
- ☐ Read to patient
- ☐ Errands

PROBLEMS/CONCERNS STATED BY PATIENT OR FAMILY

- ☐ Legal
- ☐ Food
- ☐ Physical Needs
- ☐ Financial
- ☐ Counseling
- ☐ Other _____
- ☐ Emotional Support
- ☐ Spiritual Support

PLAN OF CARE

- ☐ Contact Hospice Office
- ☐ Contact Patient/Family by Phone
- ☐ Schedule Another Visit
- ☐ Other _____

COMMENTS

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Signature _____

CONTACT RECORDS MUST BE SUBMITTED WITHIN 1 WEEK AFTER CONTACT.