Volunteer Visit Report
Patient/Family Support

Procedures: ***Use black ink only*. Please complete, sign and return this form to your volunteer manager after each patient/family visit or telephone contact. To make changes on this form, please *do not use white out.* Simply cross through mistake once, write in any changes and initial.**

Patient Name: ______________________________ Hospice Pt.#: _____________ Date: ________

Patient Location: ___Private Home ___Hospice Residence
___Nursing Home ___Assisted Living Facility ___Hospital

Patient Visit Start Time: ______AM/PM Patient Visit End Time: _____AM/PM
Total Volunteer Time: ______ (in ½ hour increments) Round Trip Mileage: ______

VOLUNTEER ACTIVITY	**ADDITIONAL ACTIVITY**	**VISIT SCHEDULE**
Check all the activities that apply to this visit.	Indicate any "special" activities you did with your patient/family (i.e. "Reflections" Journaling, a special outing, etc.)	Check the schedule you have set with the patient/family.
___ Respite Sitting (Caregiver Out)	____________________________	__ Weekly
___Companion to Patient	____________________________	__ Bi-Weekly
___ Companion to Caregiver/Family	____________________________	__ Monthly
__ Telephone Contact (.5 hours)	____________________________	__ As Needed
__ Transportation	____________________________	__ Other:___________________
__ House/Yard Work	____________________________	
___11th Hour		
___Spiritual Support		

VOLUNTEER OBSERVATIONS

We encourage you to add any *observations* you would like the team to know about your visit with the patient and/or family member/s.

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Did volunteer note any concerns/changes since last visit ? ___YES ___NO
If YES, Volunteer reported concerns/changes of:____

on: ________________________To:____________________________________ ______________________
Date and Time IDG Member Name Discipline (RN, SW, Chaplain, On Call)

Did volunteer deliver any medications to patient/family? ___YES ___NO
If YES, the medications were delivered to:_____________________________ ___________________________
Signature / Patient or Family Member Print Name

Volunteer:__________________________________ **Volunteer Manager:**______________________________
Signature **Signature**