

Volunteer Visit Report  
Patient/Family Support



Patient Name: \_\_\_\_\_ Hospice Patient # \_\_\_\_\_

**Procedures:** Use black or blue ink only. IMPORTANT - Please complete, sign and return this form to your volunteer manager after completing patient/family visits or telephone calls. You may document a single contact on this form or multiple visits/phone calls to a patient/family. Please submit in a timely manner, weekly or bi-weekly. To make changes on this form, please do not use white out. Simply cross through mistake once, write in any changes, date and initial. All visit reports must be returned no later than the last day of every month.

**PATIENT VISITS/OBSERVATIONS**

We encourage you to document your observations on the lines below each contact. Please include a description of what you did with the patient/family and anything important that you observed during your visit. Note: Please call Covenant right away to report anything that is urgent such as pain/symptom control issues, changes in the patient's condition, or other concerns related to the patient/family.

Date \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM to \_\_\_\_\_ AM/PM Total contact time \_\_\_\_\_ (1/2 hour increments)

Round Trip Mileage \_\_\_\_\_ Volunteer Service provided (please check):  Telephone Contact  
 Patient Support  Caregiver Support  Other Family Support  Patient Safety  Spiritual Support  11<sup>th</sup> Hour  
Observations:

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Date \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM to \_\_\_\_\_ AM/PM Total contact time \_\_\_\_\_ (1/2 hour increments)

Round Trip Mileage \_\_\_\_\_ Volunteer Service provided (please check):  Telephone Contact  
 Patient Support  Caregiver Support  Other Family Support  Patient Safety  Spiritual Support  11<sup>th</sup> Hour  
Observations:

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Round Trip Mileage \_\_\_\_\_ Volunteer Service provided (please check):  Telephone Contact  
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Observations:

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Date \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM to \_\_\_\_\_ AM/PM Total contact time \_\_\_\_\_ (1/2 hour increments)

Round Trip Mileage \_\_\_\_\_ Volunteer Service provided (please check):  Telephone Contact  
 Patient Support  Caregiver Support  Other Family Support  Patient Safety  Spiritual Support  11<sup>th</sup> Hour  
Observations:

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Volunteer – Print Name: \_\_\_\_\_ Volunteer - Signature: \_\_\_\_\_

Volunteer Manager/ /Volunteer Assistant - Signature: \_\_\_\_\_