

# 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 1/2 hour increments) Round Trip Mileage: \_\_\_\_\_

<b><u>VOLUNTEER ACTIVITY</u></b>	<b><u>ADDITIONAL ACTIVITY</u></b>	<b><u>VISIT SCHEDULE</u></b>
Check all the activities that apply to this visit. <input type="checkbox"/> Respite Sitting (Caregiver Out) <input type="checkbox"/> Companion to Patient <input type="checkbox"/> Companion to Caregiver/Family <input type="checkbox"/> Telephone Contact (.5 hours) <input type="checkbox"/> Transportation <input type="checkbox"/> House/Yard Work <input type="checkbox"/> 11 <sup>th</sup> Hour	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. <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> As Needed <input type="checkbox"/> Other: _____

### 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