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 _____ ☐ Closure Made

COMMENTS

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Volunteer Signature: _____

CONTACT RECORDS MUST BE SUBMITTED WITHIN 1 WEEK AFTER CONTACT.