



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/Delivery _____
- 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
- Errand

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

Signature _____

CONTACT RECORDS MUST BE SUBMITTED WITHIN 1 WEEK AFTER CONTACT.