☐ GJ ☐ PV ☐ Montrose ☐ Delta ☐ Meeker

HopeWest

# Volunteer Patient Care Documentation

(***Call HopeWest office immediately if patient or caregiver appears to be in a crisis situation.***)

**Please use blue ink and document each visit on its own form.**
**Return completed form to HopeWest at the end of each month.**

| **Patient ID #** | **Date** |
|---|---|
| **Patient Name (Last)** | **(First)** |
| **Patient Program** (Circle Program at time of visit) **Hospice Care** **Palliative Care** (Transitions, Living with Cancer, Journeys) | |

**Services provided (Please choose only one)**

| | | | |
|---|---|---|---|
| ☐ Acupuncture | ☐ Funeral/Closure Visit | ☐ Haircut | ☐ Life Stories |
| ☐ Massage/Therapeutic Touch | ☐ Music Visit | ☐ Notary Service | ☐ Patient Visit |
| ☐ Pet Therapy | ☐ Telephone Call | ☐ Transportation | ☐ Vigil Care |
| ☐ Spiritual Support | ☐ Attempted Visit | ☐ Reiki | |

Time In_____ Time Out_____ Mileage to and from your home _____

_____ + _____ = _____

Direct time with patient Indirect time (charting, travel, communication with staff) Total volunteer time

**Location** ☐ Patient Home ☐ Nursing Home _____ ☐ Hospital_____
☐ Assisted Living _____ ☐ Hospice Care Center
☐Other _____

**Patient's status at time of visit**

| | | |
|---|---|---|
| ☐ Awake | ☐ Sleeping | ☐ Confused or disoriented |
| ☐ Appeared comfortable | ☐ Appeared in pain** | ☐ Appeared agitated** |
| ☐ Appeared to be coping well | ☐ Withdrawn | ☐ Emotionally distressed** |
| ☐ Depressed** | ☐ Angry | |

☐ Other symptoms out of control** _____

**Caregiver's status at time of visit** ☐ Not present ☐ Appears to be coping well ☐ Appears exhausted/emotionally distressed**

**(**Notify Volunteer Coordinator or appropriate team member if a change occurs in patient)**

Other comments _____

_____

_____

_____

Frequency Planned _____

**Communication with Other Team Member (Name):_____Date:_____**

Volunteer Name (print) _____

Volunteer Signature_____ Date _____