☐ GV ☐ Montrose ☐ PV ☐ Delta ☐ Meeker

HopeWest

Volunteer Patient Care Documentation

(*Call HopeWest at: 1(866)310-8900 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** **PACE** **Palliative** (Transitions, Living with Cancer, Journeys)	
Pre-Visit Screening **Patient Screening Clear: Yes___ No___** **Self Screening Clear: Yes___ No ___**	

Any Symptoms:	**Fever Today?**	**Exposure?**
Cough, Fever, Chills, Shortness of Breath, Body Aches, Headache, Sore Throat, Fatigue/tiredness, change in smell or taste If any "yes" cancel visit & Call HopeWest	Current temp is >100 If "yes" cancel visit & Call HopeWest	Any Contact with Persons who are COVID+ or have COVID symptoms? Unvaccinated and international travel within 10 days? If "yes" cancel visit & Call HopeWest

Volunteer Service Performed:

☐ Acupuncture	☐ Life Story	☐ Pet Therapy	☐ Transportation
☐ Acknowledgement	☐ Light Housekeeping	☐ Reading	☐ Yard Work
☐ Companion	☐ Massage	☐ Reflexology	☐ Vigil
☐ Correspondence	☐ Meal Preparation	☐ Reiki	☐ Other_____
☐ Hair Cut	☐ Memory Bears	☐ Respite Care	
	☐ Music	☐ Shopping/ errands	
	☐ Pet Assistance	☐ Spiritual Support	

Time In_____Time Out_____Mileage to and from your home _____

_____ + _____ = _____

Direct Time with Patient Indirect Time Total Time

(Charting, travel, communication with staff)

Location: ☐ Patient Home ☐ Nursing Home _____ ☐ Assisted Living_____☐ FCC

☐Other _____

Patient's status at visit:

☐ Awake	☐ Depressed **	☐ Angry	☐ Other**_____
☐ Appeared Comfortable	☐ Sleeping	☐ Confused or disoriented	
☐ Appeared to be coping well	☐ Appeared in pain **	☐ Appeared agitated **	
	☐ Withdrawn	☐ Emotionally distressed	

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)

Frequency Planned_____

Volunteer Name (print)_____

Volunteer Signature _____Date_____