PATIENT VOLUNTEER CONTACT REPORT

Patient Name:_____ **Medical Record #**_____

Date:_____ Time Begin:_____ End:_____ Total Patient Care Time:_____

Odometer Start:_____ Stop:_____ Total Miles:_____ Total Travel Time:_____

Family Services:
____ Respite Sitting
____ Companion to patient
____ Companion to PCG
____ Companion to children
____ Reading/letter writing
____ Grocery shopping
____ Meal preparation
____ Other_____

Personal Care:
____ Make-up
____ Polish nails
____ Brush hair
____ Dressing
____ Other_____

Contacts:
____Visit
____Phone Call
____Card Sent
____ Next visit planned_____ (date)
____ No visit planned, volunteer to call
____ No visit planned, family to call

Transfer Patient From:
____ Bed to wheelchair
____ Bed to commode
____ Wheelchair to walker

Volunteer not used this week because:
____ Ample family/friend support
____ Family plans exclude volunteer
____ Refused volunteer visit
____ Volunteer on leave (family notified)
____ Patient died _____ (date)

Chore Service:
____ Housework
____ Household repairs
____ Yard Work
____ Other_____

Location:
____ Home
____ Hospice Home
____ Hospital
____ Nursing Home
____ Other_____

Bereavement:
____ Funeral Home visitation
____ Funeral attended
____ Home visit
____ Phone call
____ Sent card
____ Other_____

Observations/Comments: _____

_____

_____

Patient/PCG:_____* **Date:**_____
(signature*)

Volunteer:_____* **Date:**_____
(signature*)

Manager of Volunteer Services:_____ **Date:**_____
(signature)

***BLACK INK ONLY (no other color is Medicare-compliant)**

Return to Farrah Harrison, MVS; HRC, PO Box 281, Wentworth, NC 27375