HENDRICK Hospice Care

Patient Name: _____ **HHC#:** _____

Nursing Facility_____ **Home (city):** _____

Volunteer Documentation Form

Volunteer Name (print): _____

Date of Contact (month/day/year): ____/____/____ **Total Time**(include travel time):_____

Miles (round trip): _____ **Reimbursement for mileage requested?** ☐**Yes** ☐**No**

Type of contact (select one):

☐**Mail** ☐**Phone** ☐**Bereavement** ☐**Visit to:** ☐Home ☐Nursing Facility ☐Inpatient unit ☐Other

Services Provided (check all that apply):	**Brief Comments/Description:**
☐ *First contact to* ☐ *patient* ☐ *caregiver*	
☐ *Social support/visiting for* ☐ *patient* ☐ *caregiver*	
☐ *Emotional support to* ☐ *patient* ☐ *caregiver*	
☐ *Sitting with patient*	
☐ *Active listening*	
☐ *Meal/food preparation*	
☐ *Meal/food delivery*	
☐ *Transportation for* ☐ *patient* ☐ *caregiver*	
☐ *Encouraged* ☐ *patient* ☐ *caregiver to reminisce*	
☐ *Flower/gift delivery*	
☐ *Caregiver respite/break*	
☐ *Errands/shopping/delivery*	
☐ *Music/singing*	
☐ *Encouragement Card/Reading/letter writing*	
☐ *Support/Check-in phone call*	
☐ *Anticipatory grief support*	
☐ *Support at time of death*	
☐ *Bereavement support*	
☐ *Funeral attendance*	
☐	

Volunteer Signature: _____ **Date:** _____

Volunteer Coordinator *(office use only)*:

☐Reviewed ☐Cost Savings ☐Bereavement Cost Savings ☐Mileage

Action taken: _____

_____

_____

Signature: _____ **Date:** _____