☐ 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 ☐ Sitter for Agitated Patient
☐ HCC Hands-On Assistance

Time In_____ Time Out_____ Mileage to and from your home _____

_____ + _____ = _____

Direct time with patient | Indirect time (Charting, travel, communication with staff) | Total 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☐ Appeared to be coping well ☐ Withdrawn ☐ Emotionally distressed**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 _____