

**ASPIRUS KEWEENAW HOME HEALTH AND HOSPICE
VOLUNTEER REPORT**

Please use Black or Blue ink. No white out, Draw line through error and initial. ONLY ONE VISIT PER FORM

Patient Full Name _____ Date of Visit _____ MedRec# _____

LOCATION OF PATIENT: Home Nursing Home Omega House Other _____

SERVICES PROVIDED:

<input type="checkbox"/> Respite	<input type="checkbox"/> Caregiver Companionship/Support	<input type="checkbox"/> Telephone Contact
<input type="checkbox"/> Friendly Visit, Socialization	<input type="checkbox"/> Staff Support	<input type="checkbox"/> Spiritual Support

<input type="checkbox"/> Personal Care:		
<input type="checkbox"/> Linen Change	<input type="checkbox"/> Light Household Tasks	<input type="checkbox"/> Shopping/Errands
<input type="checkbox"/> Transfer	<input type="checkbox"/> Cooking/Dishes	<input type="checkbox"/> Laundry
<input type="checkbox"/> Toilet Need	<input type="checkbox"/> Vacuuming / Dusting	<input type="checkbox"/> Comfort Measure/Massage
<input type="checkbox"/> Hair	<input type="checkbox"/> Patient Feeding	

<input type="checkbox"/> Bereavement	<input type="checkbox"/> Life Review	<input type="checkbox"/> Other _____
<input type="checkbox"/> Visit	<input type="checkbox"/> Telephone call	
<input type="checkbox"/> Support at time of death		
<input type="checkbox"/> Funeral	<input type="checkbox"/> Support Group	

On arrival, patient was in:
<input type="checkbox"/> Bed <input type="checkbox"/> Wheelchair
<input type="checkbox"/> Reclining Chair
<input type="checkbox"/> Other _____

On arrival, patient was located in:
<input type="checkbox"/> Bedroom <input type="checkbox"/> Activity Area
<input type="checkbox"/> Hallway <input type="checkbox"/> Dining Area
<input type="checkbox"/> Other _____

On arrival, patient was: (check all that apply)
<input type="checkbox"/> Awake <input type="checkbox"/> Non-responsive <input type="checkbox"/> Easily aroused <input type="checkbox"/> Asleep <input type="checkbox"/> Other _____

At end of visit, patient was: (check all that apply)
<input type="checkbox"/> Alert <input type="checkbox"/> Talkative <input type="checkbox"/> Comfortable <input type="checkbox"/> Agitated <input type="checkbox"/> Asleep <input type="checkbox"/> Other _____

Did patient complain of pain? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, tell what you did about it.</i>
<input type="checkbox"/> Patient took meds <input type="checkbox"/> Patient refused to take meds left by caregiver
<input type="checkbox"/> Notified caregiver <input type="checkbox"/> Notified the Hospice office

VISITS (Substitute/Cancelled / Missed)
<input type="checkbox"/> Volunteer unable to visit (Date _____) <input type="checkbox"/> Sub needed called VC <input type="checkbox"/> No sub needed
<input type="checkbox"/> Patient cancelled /refused visit (Date _____) per telephone call <input type="checkbox"/> Missed visit
<input type="checkbox"/> Please send more forms/envelopes for this patient

Additional Comments: _____

Print Name _____ Volunteer Signature _____

Patient Time

Travel Time

Round Trip Miles

Next Scheduled Visit Date

Volunteer Coordinator Signature _____ Review Date _____

NOTE: This form is to be turned in after EVERY visit within 24 hours. Call 906-337-5700 if you need to talk to a hospice team member.