

VOLUNTEER NOTE

Patient Name: _____ MR #: _____ Date: _____

Start of care date: _____ Age: _____ DOB: _____ Dx: _____

Type of In-person Telephone
Visit Scheduled Unscheduled (specify): _____
Info: Time in: _____ am pm Time out: _____ am pm

PAIN MANAGEMENT

Is patient experiencing pain? No Yes *If yes, contact nurse unless declined by patient/PCG.* Declined

Name of Nurse: _____ Date/time contacted: _____

OBSERVATIONS AND SERVICES

Observations of the patient and family:

Services provided (Check all that apply): Companionship/Reading Letter writing/E-mail Errands
 Simple food preparation Light housekeeping Other (specify): _____

Patient/Family response to services
(e.g., expressed gratitude, appeared happy to see me, expressed desire for more visits, expressed dissatisfaction):

OTHER INFORMATION/COMMENTS

Continued on another sheet

Hospice Staff Name (printed) _____ Title _____ Signature _____ Date _____

Facility Staff or PCG Name (printed) _____ Signature _____ Date _____