Samaritan Healthcare & Hospice

Patient/Family Support Volunteer Documentation

PT NAME: _____ **CLINICAL #:** _____

VOLUNTEER: _____ **VOL ID #:** _____

NOTE: On your FIRST visit with a patient, verify the patient's identity with two of the following identifiers. Circle two:

1. **Name**
2. **Address**
3. **Introduction by family member or staff**
4. **Known to volunteer**

Date _____ **Initial** _____

TYPE	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)	DATE / HOURS / CODE(S)
Phone Calls	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____	**Date:** _____ **# Hours:** _____ **Code(s):** _____

Codes for Calls:
1. Left message **2.** Spoke with patient/family/caregiver **3.** Spoke with patient/family/caregiver – *Visit Canceled* **4.** Bereavement

Visits					
	Date:_____ **# Hours:**_____ **Code(s):** _____	**Date:**_____ **# Hours:**_____ **Code(s):** _____	**Date:**_____ **# Hours:**_____ **Code(s):** _____	**Date:**_____ **# Hours:**_____ **Code(s):** _____	**Date:**_____ **# Hours:**_____ **Code(s):** _____

Codes for Visits:

- **A.** Conversed with patient
- **B.** Sat quietly with patient
- **C.** Read to patient
- **D.** Listened to music/watched TV with patient
- **E.** Conducted life review/made scrapbook
- **F.** Played games/cards with patient
- **G.** Went for walk with patient
- **H.** Light meal/beverage preparation
- **I.** Light housekeeping
- **J.** Helped with gardening/yard work
- **K.** Took patient on outing
- **L.** Took patient/caregiver to appointment
- **M.** Conversed with family/caregiver
- **N.** Ran errands for patient/caregiver
- **O.** Visit canceled upon arrival
- **P.** Bereavement (funeral/viewing/services)
- **Q.** Other_____

Volunteer Signature: _____ Date: _____

Volunteer Coordinator Signature: _____ Date: _____

NOTE: Activity time is rounded to the nearest Quarter hour and includes travel time.
Remember – please return your forms **MONTHLY**!
Thank You!!