Willamette Vital Health
HOSPICE CARE

Volunteer Patient Progress Report

Patient/Client Name: _____ **Account #**_____

Volunteer: _____

Volunteer phone number: _____

Date _____ Time Spent _____ Travel Time _____

Do you want mileage reimbursement? Yes☐ No☐ Number of miles (round trip) _____

Information for the Interdisciplinary Team
Did you inquire if the patient was in pain? Yes☐ No☐ If No, state reason: _____
If the patient indicated she/he was in significant pain, did you notify the Hospice RN? Yes☐ No☐

Assignment: ❑Respite ❑Visitation ❑Pet Therapy ❑Practical Assist ❑Haircut ❑Veteran ❑Vigil ❑PPOM

Provided for Patient Needs by:_____ ❑N/A

Supported Quality of Life through: _____

Assisted Caregiver by: _____ ❑N/A

Other: _____

Changes observed in patient functioning, care giving status, living environment *(optional)*:

Volunteer Signature_Electronically Submitted_____ Date_____

CONFIDENTIALITY NOTICE

This documentation may include confidential information from the patient record which is protected by Oregon State Law and Health Insurance Portability and Accountability Act of 1996, prohibiting you from making any further disclosure of such information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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