

HOSPICE OF THE CAROLINA FOOTHILLS
VOLUNTEER CONTACT REPORT

PATIENT: _____ **ID/CODE:** _____
Last Name, First Name Include P, N, or S

(Record the date of the visit, time you enter and leave the person's home or room, circling a.m. or p.m., and your total travel time and total mileage round trip in the space provided below.)

DATE OF CONTACT: _____

CONTACT TIME: Arrival: _____ a.m. / p.m. Travel Time: _____ Mileage _____
Departure: _____ a.m. / p.m.

PLACE OF VISIT:

Place of visit: Home/Assisted Living Nursing Facility _____ Hospital _____

TYPE OF CONTACT:

Telephone Visit Errands/Transportation

SERVICES PROVIDED:

Companionship Reading Play music/Sing
 Help with hobbies/interests Caregiver relief 11th Hour
 Light yard work/gardening Provide favorite foods Errands/Transportation
 Caring Canines One Time Only Visit Hair Cut
 Life Review Other needs _____

VOLUNTEER SUMMARY

SIGNATURE OF VOLUNTEER: _____

(Please sign and submit Volunteer Contact Report within 72 hours of patient visit. Reports should be mailed or delivered to 130 Forest Glen Dr., Columbus, N.C. 28722.)

FOR OFFICE USE ONLY: Date Received: _____ Date Reviewed: _____
Concerns reported to: <input type="checkbox"/> not applicable _____
Staff Signature: _____