

## HOSPICE OF HOPE, INC. Volunteer Care Record

(Volunteer complete; return to Volunteer Coordinator by the end of each week)

**P L E A S E   P R I N T**

Patient Name/Office Location: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Time in/arrived: \_\_\_\_\_ Time out/left: \_\_\_\_\_

Volunteer Name: \_\_\_\_\_

Description of duties provided by the volunteer during this visit:

√	DESCRIPTION (Patient Care)	Total Hours	√	DESCRIPTION (Office)	Total Hours
	Companionship			General Office Work	
	Caregiver Relief			Patient Files	
	Pt. Assistance Calls			Billing Files	
	Comfort Care			Admission Packets	
	Funeral/Visitation			Data Entry	
	*Facility: _____			Shredding	
	Veterans Salute			Bulk Mailing	
	Beautician/Massage Therapist			Bereavement	
	Therapy (Animal, Music, Aroma, etc.)			Gardening/Flower Arrangements	
	Transportation			Community Events	
	Sewing/Knitting			Fundraising	
	Housekeeping			Other: _____	
	Other: _____				

\*Please note Care Center/IPC/Nursing Home name.

### VOLUNTEER OBSERVATIONS/NOTES

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\_\_\_\_\_  
 Signature of Volunteer

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 Total hours for Visit