



Visit Date _____

Patient _____ MR# _____

Time In _____ Time Out _____ Length of Visit _____

Mileage _____ Travel time _____

Person Served	Location of Service	Type of Activity
_____ Patient	_____ Home	_____ Visit
_____ Caregiver	_____ Nursing Home	_____ Telephone Call
_____ Bereaved	_____ Hospital	_____ Bereavement
_____ Other	_____ Group Home	_____ Other
	_____ Assisted Living Facility	

Interventions: Check all that apply

- | | | |
|-------------------------|---------------------------------|------------------------|
| _____ Companionship | _____ Bereavement | _____ Food preparation |
| _____ Cg Relief | _____ Telephone call | _____ Household chores |
| _____ Emotional support | _____ Excursion / Errands | _____ Other _____ |
| _____ Socialization | _____ Music / Pet / Art Therapy | _____ Other _____ |

Check all that apply:

1. When I made my visit, the patient was:

- _____ up in a chair _____ in bed _____ in wheelchair _____ awake _____ alert _____ drowsy _____ sleeping
 _____ appeared confused _____ appeared sad _____ appeared cheerful _____ appeared calm

2. During my visit, I:

- _____ talked to patient _____ looked at pictures w/pt _____ did light housekeeping _____ confirmed patient's emotional reactions
 _____ listened to music w/pt _____ read to patient _____ took patient to activities _____ socialized with patient during volunteer visit
 _____ walked along side of patient _____ other _____

3. The patient had visitors: _____ Yes _____ No

4. Did the patient appear comfortable at the time of your visit? _____

5. Who did you notify if the patient reported pain to you? _____

6. Notified Manager of Volunteer Services of changes in patient or family concerns: _____

Volunteer Signature _____

Volunteer Name Printed _____

MVS Signature _____