VOLUNTEER PROGRESS NOTES

Patient Name: _____
Date of Visit: _____ **Start Time:**_____ **End Time:** _____
Travel Time (minutes): _____ **Documentation Time (minutes):** _____

CARE PROVIDED (check all that apply)			
___ Respite	___ Reading	___ Life Stories	___ Music
___ Emotional Support	___ Errands & Shopping	___ Companionship	___ Massage
___ Light Household Tasks	___ Light Meal/Snack Prep	___ Comforting Presence	___ Art
___ OTHER: _____			

PATIENT INFORMATION: **Please note any changes from your last visit.

COMMUNICATION IMPAIRMENTS	**HOME ENVIRONMENT**	**SPECIAL PRECAUTIONS**
___ Speech	___ Private Residence	___ Ambulating
___ Vision	___ Assisted Living/Nursing Home	___ Equipment
___ Hearing	___ Animals	___ Diet
___ Memory Cognition	___ Smoking	___ Swallowing
___ Other: _____	___ Other: _____	___ Oxygen
		___ Other: _____
PSYCH/SOCIAL ISSUES	**CURRENT MOBILITY**	**TOILETING**
___ Alert/Oriented ___ Mood Swings	___ Wheelchair ___ Walker	___ Incontinent
___ Drowsy ___ Denial	___ Bed Bound ___ Cane	___ Catheter
___ Depressed ___ Angry	___ Needs Assistance	___ Colostomy
___ Judgement Deficits		___ Bedpan/Urinal
___ Isolated		___ Bedside Commode
___ Religious Preference: _____		___ Independent Toileting

Was the patient comfortable by the end of the visit?

___ YES ___ NO *** PLEASE NOTIFY STAFF IMMEDIATELY OF ANY SIGNIFICANT CHANGES***

If NO:
Team member notified: _____ **Date & Time**: _____

Visit Notes (Brief narrative of visit):

_____

_____

_____

_____

_____

Volunteer Signature: _____ Date: _____

Volunteer Coordinator Signature: _____ Date: _____