



14 McKenzie Avenue
Ellsworth, ME 04605

Tel 207.667.2531
Fax 207.667.9406

Email: info@hospiceofhancock.org

MONTHLY PATIENT CARE REPORT

Please note: HVHC's State License requires documentation of volunteer service for each patient / family in the patient folder. Please complete a report form for each patient on a monthly basis. Record time in appropriate box, in ¼ hour segments (.25, .50, .75, 1, etc.). If a visit includes more than one service, record time spent in principal service (i.e., "respite" and check other boxes).

PATIENT NAME: _____ **MONTH:** _____, 20__

VOLUNTEER NAME: _____ **REGION:** _____

Date							
Initial Assessment							
Emotional Support/Companionship Visit							
Respite							
Chores, Errands, Meals							
Emotional Support / Telephone							
Transportation of Patient / Family							
Bereavement Follow-up							
Other Service to Patient / Family							
Travel Time							

Signature: _____ **Date:** _____

TOTAL TIME SPENT IN PATIENT CARE FOR MONTH: _____ hours

TOTAL TRAVEL TIME FOR PATIENT CARE FOR MONTH: _____ hours

Comments: Please indicate your observations on the following: 1. Change in patient condition; 2. Patient pain/comfort issues; 3. Patient/Family issues.

Visit 1.

Visit 2.

Recorded in DB: _____

(over)

Visit 3.

Visit 4

Visit 5.

Visit 6

Visit 7.
