# Volunteer Patient Progress Report

Patient/Client name:____________________________________________MRN #_____________________

Volunteer:_______________________________________________________________________________

Volunteer phone number: __________________________________________________________________

Date_______________________Time Spent________________________Travel Time_________________

Do you want mileage reimbursement? Yes_____ No_____ Number of miles (round trip)____________

## Information for the Interdisciplinary Team

***Did you inquire if the patient was in pain? Yes___ No___***

***if No, state reason:________________________________________________________________***

***If the patient indicated she/he was in pain, did you notify the Hospice RN? Yes____No____***

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Assignment: Respite Visitation Pet Therapy Practical Assist Haircut Veteran Vigil

Provided for Patient Needs by:_______________________________________________________ N/A

Supported Quality of Life through:_____________________________________________________

Assisted Caregiver by:______________________________________________________________ N/A

Other:_________________________________________________________________________________

Changes observed in patient functioning, care giving status, living environment (*optional)*:

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Volunteer Signature__________*Submitted Electronically*_____________Date______________________

**CONFIDENTIALITY NOTICE**

This documentation may include confidential information from the patient record which is protected by Oregon State Law and Health Insurance Portability and Accountability Act of 1996, prohibiting you from making any further disclosure of such information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

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Willamette Valley Hospice, 1015 Third St NW, Salem, OR 97304

2/2018