

6/2014



## 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 \_\_\_

Note changes in patient/client functioning, care giving status, living environment (be specific):

Comments (request for forms, for a call from Volunteer Coordinator or other team members):

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