Hand In Hand HOSPICE

Volunteer Initial Assessment/Care Plan

Request for Volunteer ☐ Yes ☐ No Staff Signature _____ Date _____

Patient Name:		ID#	Referral Date:	
Address:	City:		State:	Zip Code:
Phone#	Age:	Date of Birth:	Assessment Performed ☐Home Visit ☐Phone	Date:
Diagnosis:				
Caregiver Name:	Relationship:		Phone:	

Directions:
_____
_____

LOCATION OF SERVICE	ACTIVITIES REQUESTED	FREQUENCY
☐Home	☐Light Meal Preparation	
☐Nursing Home	☐Light Housekeeping	
☐Other	☐Other	

PSYCHOSOCIAL SERVICE	FREQUENCY	COMMENTS:
☐Companionship		
☐Caregiver Respite		
☐Emotional Support		
☐Patient		
☐Caregiver		
☐Family Support		
☐Other(specify)		

Assessment ☐DNR ☐Lives alone ☐Lives with_____ ☐Alone during the day ☐Bed Bound ☐Up as tolerated	☐Partial weight bearing ☐Non-weight bearing	☐Vision Deficit ☐Glasses ☐Other ☐Hearing deficit ☐Hearing aid ☐Seizure precautions ☐Speech/Communication deficit	☐Dentures ☐Oriented x 3 ☐Alert ☐Forgetful/Confused ☐Diabetic	☐Pain medication ☐Oxygen

Patient Likes:	Pets in Home: ☐ Dog ☐Cat ☐ Bird ☐Other_____
Patient Dislikes:	Smoking in Home: ☐ yes ☐ no
Subjects to Avoid	Volunteer Preferred: ☐Female ☐ Male ☐ No Preference

Comments:
_____
_____

Volunteer Assigned:	Date:
Volunteer Coordinator Signature:	Date