Hospice of Huntington Volunteer Services

Request and Plan of Care

Request Date _____ **Team #**_____ **Patient MRN**_____

Patient Name _____

Primary Caregivers _____

Requested by (Staff Member) _____

Days of Week – M T W TH F SAT SUN Hours _____ **None Specified** _____

One time only visit (Date & Time)_____

Patient Information *(Check all that apply)*

	Oriented		**Bedside Commode**		**Cat(s) in Home**
	Confused at Times		**Incontinent of Bowel & Bladder**		**Dog(s) in Home**
	Dementia		**Wears Adult Briefs**		**Patient lives alone**
	Ambulatory		**Foley Catheter**		
	Assist in Ambulating		**Walker**		
	Bedfast		**Wheelchair**		
	Oxygen		**Smoking in Home**		

Services Requested *(X all specific services that are requested)*

	Transportation		**Caregiver Appointment**
	Hair Cut		**Caregiver Socialization**
	Clergy		**Caregiver Respite**
	One Time Only Visit		**Massage Therapy**
	Continuing Weekly visits		**Shopping/Errands**
	Patient Companionship		**Vigil sitting at bedside**
	Patient Socialization		**Pet Therapy**
	Light Meal Preparation		**Bereavement Visit**
	Pets		**Other**

To be completed by volunteer office

Volunteer Assigned _____
Phone_____
Assigned by_____
Date _____
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COMMENTS:

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