

**HOSPICE OF DAVIDSON COUNTY  
VOLUNTEER CONTACT SHEET  
INDIVIDUAL PLAN OF CARE FOR:**

**Patient:** \_\_\_\_\_ **Record #:** \_\_\_\_\_

**Please fax, mail, e-mail or complete this form on-line weekly after each visit to insure Medicare Compliance.  
Fax: 474-2081 e-mail: whedrick@hospiceofdavidson.org  
This form may be downloaded or completed on-line at hospiceofdavidson.org in the Volunteers section – For Our Volunteers**

**\*\*\*\*This Individualized Plan of Care volunteer contact record should mirror the POC sent to you by the Volunteer Coordinator w/ this patient's fact sheet. This validates that your efforts and contact is in line with the PT/FAM request/s and this patient's POC. \*\*\*\***

PT/FM	PCG	**POC REQUEST/S <i>The following Service/s to be provided by Volunteer</i>	FREQUENCY <u>REQUIRED</u> <b>1 TO 4X</b> <b>MONTHLY</b>	DATE OF CONTACT/S	TYPE OF CONTACT	COMPLIANT <u>W/</u> <u>FREQUENCY</u> <u>Yes or NO</u>	VISIT BEGIN	VISIT END	Travel Time Begin	Travel Time End	ODOM BEGIN	ODOM END	Contact Type	Code
		RESPITE											Telephone	TE
		COMPANIONSHIP											Home Visit	HMV
		LIFE REVIEW											Hospital Visit	HOV
		ERRANDS											Other (specify)	O
		PHONE SUPPORT											Visit w/patient	PV
		HAIRCUT											Visit w/family	FM
		OTHER											Caregiver Relief	CR
		OTHER											Errands	ER

Comments: \_\_\_\_\_  
\_\_\_\_\_

Contacted: \_\_\_\_\_ regarding the following issues/concerns: \_\_\_\_\_  
(HODC Staff Member)  
\_\_\_\_\_

Date Contacted: \_\_\_\_\_ Reimburse Mileage YES or NO: \_\_\_\_\_ Mail Volunteer Additional Contact Sheets: \_\_\_\_\_ Need Self Addressed/Stamped Envelope: \_\_\_\_\_

Volunteer: \_\_\_\_\_ Date: \_\_\_\_\_ Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_