

Volunteer Services
Progress Note
Hospice of Central Michigan, Inc.

Client Name: _____ Contact Date: _____

(Please use black ink)

Time of Contact: _____ to _____

Type of Contact: () Visit () Phone Call

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Please describe who you had contact with and what happened during the contact: _____

Concerns: _____

Follow-up referred to: _____ Director _____ Office Manager

_____ RN _____ SWK _____ HHA

_____ Spiritual _____ Bereavement _____ Volunteer
Coordinator Coordinator Coordinator

_____ Patient Care Coordinator _____ No follow-up needed

() Office will enter my hours

() I will enter my own hours

() Mileage (if you wish to receive payment for mileage please fill out mileage form. Reimbursement of 14cents a mileage)

Volunteer Signature

Volunteer Services Coordinator

Use one form per visit. Please mail: 401 S. Main, fax: 989-773-1072, or drop off, progress notes before the end of each month. Thank you