

(Name of Organization) VOLUNTEER ASSIGNMENT SHEET

CLIENT/FAMILY INFORMATION

1. Client's Name: _____ ID#: _____
2. Care Givers:
 - a. Primary: _____ Relationship _____ Comments: _____
 - b. _____ Relationship _____ Comments: _____
 - c. _____ Relationship _____ Comments: _____
 - d. _____ Relationship _____ Comments: _____
3. Significant Dates (Wedding, Anniversary, etc.): _____
4. Religious Affiliation: _____
5. Occupation: _____
6. Client's Condition: _____
 - a. _____ Lives alone
 - b. _____ Alone during day
 - c. _____ Bed bound
 - d. _____ Up as tolerated
 - e. _____ Other
7. Client pertinent/precautionary information
 - a. _____ Speech/communication deficit
 - b. _____ Alert
 - c. _____ Oriented
 - d. _____ Lethargic
 - e. _____ Confused
 - f. _____ Denying
 - g. _____ Accepting
 - h. _____ Vision deficit
 - i. _____ Hearing deficit
 - j. _____ Other _____
8. Client/Family Needs (please check)
 - a. Time of day help is needed: AM _____ PM _____ Weekend _____ Weekday _____
Evening _____ Other _____
 - b. Recreation _____
 - c. Meal preparation _____
 - d. Housekeeping _____
 - e. Sitting with patient _____
 - f. Sitting with Others _____
 - g. Bereavement Visits _____
 - h. Shopping _____
 - i. Emotional Support-Active Listening:
 - i. Personal Contact _____
 - ii. Phone Contact _____
 - j. Spiritual Support _____
 - k. Other _____
9. Volunteer Name: _____
 - a. Phone Number: Home _____ Work _____ Cell _____
 - b. Date of Assignment: _____

Staff Member making Referral Signature

Date

Manager of Volunteer Service Signatures

Date