cascade HEALTH SOLUTIONS
Hospice Care

Volunteer Hours Report – *Massage Therapy*

VOLUNTEER NAME:_____ **MONTH/YEAR:**_____

Thank you for entering total time by category below:

Patient Care Hours *	
Education / Training Hours	
TOTAL HOURS	

* Patient care hours include phone call & travel time. Round up to nearest ¼ hour.

Please list one patient per page

Patient's Name _____ Total Time _____ Date _____

Goals of Therapy: Please rate discomfort level (using 1-10 scale)

Relaxation: Before_____ Base Pain: Before _____ Distressing Symptoms: Before _____

After _____ After _____ After _____

Massage:	Healing Touch:	Reiki:	Music:
Aroma Therapy:	Acupuncture:	Guided Imagery:	Other:

Patient's Response_____

_____

_____

Patient's Name _____ Total Time _____ Date _____

Goals of Therapy: Please rate discomfort level (using 1-10 scale)

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Massage:	Healing Touch:	Reiki:	Music:
Aroma Therapy:	Acupuncture:	Guided Imagery:	Other:

Patient's Response_____

_____

_____

Please mail, email or fax your completed form at the end of each month or upon the death of your client to:

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