Patient Name: ID #: H

* RETURN ACTIVITY LOGS WITHIN 7 DAYS OF THE VISIT *

What was the purpose of your contact? (Check all that apply.)

Check	Code	Activity	Date	Travel Time (Hours: Minutes) (Round Trip)	Start Time	End Time	Mileage (Round Trip)
	H680	Phone call/e-mail					
	H300	Face-to-face visit					
	H400	Bereavement visit, attend funeral					
	H450	Transportation, errands or household assistance					
	H450	Delivery					
	A201	Team meeting					
	H300	Mentor visit					

Please include BRIEF description of support provided.

Volunteer Name – Please PRINT

Volunteer Signature **Date**

Volunteer Coordinator Signature **Date**

Data Entry By **Date**

This log may be faxed to the office
Fax #: 828-0664
or e-mailed to
vol1@transitionslifecare.org