Patient Name
Date of Birth
Sex
PHIN
Person Referring
Date of Referral

Palliative Care Volunteer Referral Form

Please FAX completed form to Volunteer Coordinator as below.

Volunteer Requested by	☐ **Self**	
	☐ **Family**	Name
		Contact No.
		Relationship
	☐ **Staff Person**	Name
		Contact No.
		Site/Program
Patient Agreed to Volunteer Services	☐ **Yes**	***Note: Patients or their substitute decision maker must agree to volunteer services for these to be arranged. The Coordinator will not arrange volunteer services if the patient has not agreed.***
Patient's Illness/Disabilities/Special Considerations		
Patient's Interests Pre-Illness		
Patient's Current Interests		
Goals of Volunteer Involvement		
Other/Background Information – Snap Shot of Current Situation		