**Hospital Volunteer Program Patient Priority List;** Date \_\_\_/\_\_\_/\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Priority** | **WARD** | **Patient Name** | **Feeding**  **assist** | **Set up** | **Encourage Fluids** | **Thickened**  **Fluids** | **Protective Equipment** | **Can walk on own with volunteer** | **Reason for referral** | |
| **YES √** | **YES √** | **YES √** | **YES √** | **YES √** | **YES√** |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention **Comment:** | ☐ ☐ ☐ |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention  **Comment:** | ☐ ☐ ☐ |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention  **Comment:** | ☐ ☐ ☐ |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention  **Comment:** | ☐ ☐ ☐ |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention  **Comment:** | ☐ ☐ ☐ |
|  |  |  |  |  |  |  |  |  | Dementia/cog impairment  Delirium  Delirium prevention  **Comment:** | ☐ ☐ ☐ |

**Volunteer program weekly discharges**

|  |  |  |
| --- | --- | --- |
| **Date Discharged** | **Name of patient discharged** | **Where the patient was discharged to** |
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