**Hospital Volunteer Program**

**Referral and eligibility checklist**

Date: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Ward:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Room: \_\_\_\_\_

SURNAME UNIT NO/UAID

FIRST NAMES DOB SEX

AFIX PATIENT LABEL

|  |  |  |
| --- | --- | --- |
| **Patients are not suitable and excluded from the program if:**   1. **The patient has behaviours that would place a volunteer at risk (eg; Hitting out or physical aggression)** 2. **The patient or carer has declined to have a volunteer visit.** | | |
| **All information below MUST be completed to ensure the safety of both the patient and volunteer**  **CRITERIA FOR PROGRAM** (circle response) | | |
| Patient is aged >65 years (or if aboriginal > 45 years) **AND** | YES | NO |
| Scored 24/30 or less on SMMSE or 7/10 or less on AMT | YES | NO |
| ***OR*** Patient has a diagnosis of dementia or obvious memory and /thinking problems | YES | NO |
| ***OR*** Is positive for suggested Delirium with Confusion Assessment Method | YES | NO |
| ***OR*** *Patient is >65 (> 45 ATSI) AND has one or more of the following delirium risk/precipitation factors*  Please tick: **Severe medical illness ( ) Dehydration ( )** **Alcohol dependant ( )**  **Depression ( ) #NOF ( ) Visual impairment ( ) Hearing impairment ( )** | | |
| **DELIRIUM ALERT** has been placed in patients MR folder | YES ☐ | |
| **CONSENT** is required before the allocation of a volunteer.  Verbal patient or carer consent obtained  NOTE: **Where consent cannot be immediately obtained and the patient who meets the referral criteria is in need of urgent volunteer support the NUM/RN in charge can refer to the program pending consent.** | YES ☐ | |
| **Additional information required from nursing staff to advise volunteers on patient requirements.**  **Volunteers cannot accept patients without this information** | | |
| ***Specific suitability considerations***;  Does the patient have communication difficulties that would prevent them from talking to a volunteer (eg aphasia) | YES | NO |
| Does the patient require **Personal Protective Equipment**? | YES | NO |
| Is the patient **safe to be walked with a volunteer**? | YES | NO |
| Does the patient need reorientating? | YES | NO |
| Does the patient need assistance with eating and drinking | YES | NO |
| If yes- type of assistance: Menu completion ( ) Set up and supervision ( ) Full assist ( ) | | |
| Is the patient on **thickened fluids**? | YES | NO |
| Does the patient need **fluids encouraged**? | YES | NO |
| Is the patient on **restricted** fluids? | YES | NO |
| Is the patient on a **Fluid Balance Chart?** | YES | NO |
| Are there any **special diet** or other needs for this patient that the volunteer should know | YES | NO |
| IF YES please specify : | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please place completed form in the Volunteer Referral folder located** | | |

Published Oct 2016. Next review 2025. © State of NSW (Agency for Clinical Innovation)