TEAR-OFF
CHAPLAIN VISIT REQUEST FORM

Name: ____________________________

Room #: ________

To better assist you, please take a moment to consider the following issues and your feelings towards them...

CHECK those which apply to you, and add comments if you wish...

**Faith, Belief, Meaning**

____ Does your life have meaning?
____ Do you consider yourself a spiritual or religious person?
____ Do your beliefs give you a sense of comfort and hope?

**Importance and Influence**

____ Do your beliefs play an important role in your daily living?
____ Do you have specific beliefs that might guide your healthcare decisions?

**Community**

____ Is there a group of people you really love or who are important to you?
____ Do you feel this community is supportive of you?
____ Do you feel lonely or isolated from your community of support?