



HOME HEALTH AIDE SUPERVISORY VISIT

Home Health Aide: _____

Date: _____

Patient: _____

Time: _____

Supervisory Visit Type:

Initial Supervisory Visit Routine Supervisory Visit Initiated at Request of Patient/Other

Was the HHA present during this supervisory visit? Yes No

Was the patient treated with respect? Yes No

Plan of Care Reviewed With: _____

Was the Plan of Care Followed? Yes No

Revisions to the Plan of Care:

Evaluation of Care:

Bath Hair Care Nail Care Shave Housekeeping Meal Assist
 Oral Care Transfers Exercise ROM Ambulation Vital Signs

Other: _____

Patient/Caregiver Response to Care:

Satisfied with care provided NOT satisfied with care provided

Specify Areas of Concern:

Was Patient/Caregiver cooperative with the care provided? Yes No

Specify: _____

Continue supervised discipline services? Yes No

Specify: _____

Notes:

Clinician: _____

Patient/Caregiver Initials: _____