



### 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: \_\_\_\_\_