Wells Brooke
CERTIFIED HOME HEALTH CARE

Supervisory Form

Patient Name: _____ MR#: _____ Date: _____

Profession Under Supervision:

☐ PTA ☐ COTA ☐ Hha: Present at Time? ☐ Yes ☐ No

Purpose of Visit: ☐ 2 Week Supervision ☐ 6 Month Skill Observation ☐ Annual Evaluation

	Yes	No	If No, explain:
• Care provided according to Plan of Care?	☐	☐	_____
• Patient/PCG verbalizes satisfaction with services provided?	☐	☐	_____
• Plan of Care remains appropriate to patient's needs?	☐	☐	_____
• Changes in Plan of Treatment?	☐	☐	_____

☐ Supplemental Order Submitted ☐ Pt./Family Informed of Changes

Additional Comments/Changes:_____

_____

_____

_____

_____

_____

Signature of Evaluator/Title: _____

Employee Name: _____

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