**AMERICAN FAMILY HOME**
**HEALTH AGENCY**

620 Alum Creek Dr. Columbus, Ohio 43205 Suite 307
Telephone (614) 252-4651 - Fax: (888) 511-0533

# SUPERVISORY VISIT FORM

Patient Name_____

Name of Aide:_____

Patient Signature _____

PERSONAL CARE EVALUATION: 4=Excellent 3=Good 2-Fair l=Poor N/A=Not Applicable

| | | | | | |
|---|---|---|---|---|---|
| Bathing | _____ | Meal Preparation | _____ | Exercise | _____ |
| Grooming | _____ | Housekeeping | _____ | Turn &reposition | ____ |
| Shaving | _____ | Laundry | _____ | Vital Signs | _____ |
| Hair care | _____ | Errands/Shopping | _____ | Catheter care | _____ |
| Oral Hygiene | _____ | Ambulation | _____ | Appointments | _____ |

CLIENT LIVES: ____ Alone

_____With family, but family is ____ Unable to provide care
____ Unavailable
____Needs assistance

Functional limitations:

Client and family are ( ) pleased ( ) displeased with the services of the Aide

AIDE'S PERFORMANCE:

PCA/HHA ASSIGNMENT SHEET IS IN THE HOME: ( ) YES ( ) NO
FOLLOWS THE PLAN OF CARE AND ASSIGNMENT AS OUTLINED: ( ) Yes ( ) No
FOLLOWS CDC HAND HYGIENE TECHNIQUES ( ) YES ( ) NO
ADEQUATELY DOCUMENTS THE CARE RENDERED: ( ) Yes ( ) No
NOTIFIED OFFICE OF PROBLEMS ENCOUNTERED: ( ) Yes ( ) No
DEMONSTRATED ACCOUNTABLIITY AND RESPONSIBILITY: ( ) Yes ( ) No
REPORTS TO WORK ASSIGNMENTS AS SCHEDULED: ( ) Yes ( ) No
WORKS THE ASSIGNED HOURS AS SCHEDULED: ( ) Yes ( ) No

COMMENTS:

_____
_____
_____
_____

_____ _____ _____
Supervisor's Signature/Title Date Time

I, _____ , have reviewed the Individual Care Plan (ICP) with my supervising RN. I understand that I must be in compliance with the ICP at all times, and that I should contact the supervising RN with any questions and/or concerns.

_____

**PCA/HHA Signature** **Date**

**Comment on the effectiveness of the Individual Care Plan:**

_____

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