PRIMA HOME HEALTH
3500 N. State Road 7
Suite 499
Lauderdale Lakes, FL 33319

FIELD SUPERVISORY REPORT
PTA

Patient Name: ______________________ Medical Record #: ______________
PT/PTA Name: ______________________ Date: ______________

	Please respond with Yes, No or NA to the following questions.	Yes	No	NA
1	Did the PT/PTA identify herself/himself and explain her/his duties at the first visit with you?			
2	Did the PT/PTA explain the care provided according to the plan of care?			
3	Did the PT/PTA provide care according to the scope of practice & in response to meet our needs?			
4	Did you feel the PT/PTA was concerned with your health?			
5	Were you able to express your feelings and opinions without reservation to the PT/PTA?			
6	Were you able to participate in the care planning process and in your care?			
7	Was the PT/PTA following dress code? Using ID badge			
8	Was the PT/PTA prepared with appropriate supplies and equipment as needed?			
9	Was the PT/PT A on time for the visit or did he/she contact the client to change time?			
10	Did the PT IPT A follow universal precaution and safety precaution?			
11	Did the PT/PT A document care provided in the client's home chart?			
12	Did the PT/PTA maintain confidentiality while providing care to you in your home?			

	Clinical Record Supervision	Yes	No	NA
1	Did the PT/PTA adequately document assessment, teaching and treatment performed in the home record? Are changes in treatments orders reported to the Agency?			
2	Did the PT/PTA notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was this noted in the home record?			
3	Is the PT/PTA carrying out the established Plan of Care? If No, use the comment section to identify areas not addressed and the reason?			
4	Does the PT/PTA report every 14 days or less the client's condition to the MD as per agency policy? (Physician status report)			
5	Does the PT/PTA report to the Case Manager, DON any new or changed medication orders or modification to the plan or care regarding treatment orders and are these changes documented in the home record and medication sheet?			

Comments: ____

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Client information packet is present in the home? ❑ Yes ❑ No
Client understands rights/home health complaint & Abuse toll-free hotline phone number ❑ Yes ❑ No

Client comments: ____

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Supervisor's Name/Signature: ______________________ Date: ______________