MAK HealthCare Inc
1013 Cliff Road E Suite 102
Burnsville MN 55337
Tel 612-987-1120 Fax 952-426-3999

SUPERVISION OF PCA

Date ______________ **Time In**____________ **Time Out** ____________________

NAME OF CLIENT: ________________________________ **DOB** _____________________

ASSESSEMENT

Aide Present ☐ No ☐ Yes **Aides Name**: ______________________________________

Observation of: ☐ Personal Cares ☐ Ambulation/Transfer ☐ Range of Motion/Positioning
☐ Meal Prep ☐ Linen Change ☐ Laundry
☐ Emergency
☐ Medication Reminders
☐ Infection Control Techniques

Client Comments: ____

PCA Compliant with Clients Care Plan: ☐ Yes ☐ No

Comments: ____

PLAN OF CARE UPDATE

Client Care Plan Reviewed: ☐ Yes ☐ No Care Plan Update: ☐ Yes ☐ No
Services Appropriate: ☐ Yes ☐ No Services Changed: ☐ Yes ☐ No
List Changes/Updates: ____

Plan: _______ Return for Supervisory Visit_____________________________________
_______ Other

RN/LPN Signature: _________________________________ Date ________________

Client/Responsible Party Signature _________________________ Date __________________