DHHS PRIVATE DUTY NURSING SUPERVISORY VISIT FORM Fax to DHHS/DDSN Case Manager - Please Print

Provider:	Date of Visit:
Client Name:	DOB:
Client CLTC Number:	Nurse:
Is the client Medicaid eligible? How was it checked?	
Have Care Call claims been reviewed?	
Is the nurse caring for the client an RN or LPN? If the nurse is an LPN, please list the tasks that the LPN must be supervised on?	
Has the nurse completed the required minimum 6 hours training per calendar year in order to care for this client?	
Does the nurse arrive at the scheduled time?	
Has the nurse been trained to care for the needs of this particular client? i.e. ventilator care, tracheostomy care, catheter care.	
Was the nurse oriented to this client? How long has the nurse been caring for this client?	
During the visit did the supervisor meet with the Responsible Party (RP)?	
Does the RP have concerns regarding the client? Regarding the nursing care being provided? Is the nurse an appropriate match for the client?	
When the physician's orders were last updated? Is there a copy in the chart?	
Has the Plan of Care been reviewed? Has the MAR been reviewed?	
Has the Disaster Plan been reviewed?	
Does the client continue to have skilled needs?	
Has a Discharge Plan been created? What is a tentative discharge date?	
Is the client a candidate for weaning? Why?	
What goals are in place in order to actively plan for weaning?	
What is the weaning plan?	
Is the RP aware of the weaning plan? Is the RP in agreement?	
What concerns are there about weaning?	
Does the nurse have any other concerns about this client?	
Nurse Supervisor:	