Agency Name
IHSN
Clinical Orientation and Supervision Note

Name/Title of Employee (print): _____ Date: _____

Client Name (print): _____

Orientation

☐ RN ☐ LPN Completed: ☐ Home (Complete Supervision Section) ☐ Phone ☐ Office

CBSN Care treatments and procedures oriented to: _____

_____

_____

Instructions given related to the Plan of Care: _____

_____

_____

☐ Field Nurse signs/dates Nursing Plan of Care

Supervision

Name/Title of Employee (print): _____ Date: _____

☐ RN ☐ LPN

Nursing Plan of Care: ☐ Reviewed ☐ Universal Precautions Observed
☐ Clinical Skills Observed/Reviewed
Clinical Competency Form Updated: ☐ Yes ☐ No

Evaluation of Skills Performed: ☐ Satisfactory ☐ Needs Improvement

_____

_____

☐ Field Nurse is competent to carry out Nursing Plan of Care
Instructions given, if applicable: _____

_____

Signature/Title of Field Nurse: _____

Signature/Title of Nursing Supervisor: _____