Agency Name

CPCS: ORIENTATION

Employee Name (print): _____ Title: _____

Client Name: _____ Start of Care Date: _____/_____/_____

Orientation Conducted: _____Client's Home/Site _____Phone ____Office

Was the Nursing Care Plan reviewed with the CHHA? ___Yes ___ No

If not, why not? _____

TASKS TO BE PERFORMED AND FREQUENCY: (*Circle all that apply and indicate how often)*

HAND WASHING	BATHING	GROOMING	TRANSFER
AMBULATION	MEAL PREP	TOILETING	SKIN CARE
FEEDING	FOOT CARE	ROM	ORAL HYGIENE
NAIL CARE	HOYER LIFT	VITAL SIGNS	BLOOD PRESSURE
PULSE OX	OXYGEN TUBING	OTHER:	

Instructions given to CHHA related to Plan of Care: _____

_____

Were all applicable tasks discussed? YES NO

Were there revisions made to the Plan of Care? YES NO

If so, were they reviewed with the CHHA?? YES NO N/A

I have oriented the CHHA to carry out the duties required based on the client's care plan.

Nurse Supervisor Name(print): _____ Date_____/_____/_____

Signature of Nurse Supervisor: _____

CHHA Name (print): _____

CHHA Signature: _____

Rev_____