**Youth’s Name:** Click or tap here to enter text. **CHC ID:** Click or tap here to enter text.

**Date Mailed:** Click or tap to enter a date. **Youth’s Date of Birth:** Click or tap to enter a date.

**Transition Readiness Changing Roles for Youth**

**Compare your answers with your family. They might be surprised by what you know and what you want to learn. Work on a plan to increase your health care skills. Share with the medical team the skills that you are working on. It takes time and practice to learn and demonstrate these skills. Best time to start is today!**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health & Wellness 101**  **The Basic Skills** | **Does not apply to me** | **Yes I do this** | **I need to learn how** | **Someone else will have to do this. Who?** |
| **KNOWLEDGE OF HEALTH ISSUES/DIAGNOSIS** |  |  |  |  |
| I understand my health care needs, and I can explain my needs to others. |  |  |  |  |
| I understand how to take my medication and what the side effects may be. |  |  |  |  |
| I can explain to others how my family’s customs and beliefs might affect health care decisions and medical treatments. |  |  |  |  |
| I know my health and wellness measures (height, weight, Blood pressure, lab values). |  |  |  |  |
| I know about prescriptions, over the counter, and herbal medicines and when to use them. |  |  |  |  |
| I know my symptoms that need quick medical attention. |  |  |  |  |
| I know what to do in case I have a medical emergency. |  |  |  |  |
| **BEING PREPARED** |  |  |  |  |
| I carry my health insurance card every day, |  |  |  |  |
| I carry my important health information with me every day (i.e.: medical summary, including medical diagnosis, list of medications, allergy info, doctor’s numbers, drug store number, emergency contacts, etc.). |  |  |  |  |
| **TAKING CHARGE** |  |  |  |  |
| I call for my own doctor appointments. |  |  |  |  |
| I know I have an option to see my doctor by myself. |  |  |  |  |
| Before a doctor’s appointment I prepare written questions to ask. |  |  |  |  |
| I track my own appointments, prescription refills and expiration dates. |  |  |  |  |
| I call in my own prescriptions refills. |  |  |  |  |
| I have a part in filing my medical records and receipts at home. |  |  |  |  |
| I register and pay my co-pays for medical visits. |  |  |  |  |
| I help monitor my medical equipment so it’s in good working condition (daily and routine maintenance) and know who to contact if it needs to be fixed. |  |  |  |  |
| **After age 18** |  |  |  |  |
| My family and I have a plan so I can keep my healthcare insurance after I turn 18 and 26. |  |  |  |  |
| I sign my own medical forms (HIPAA, permission for treatment, release of records). |  |  |  |  |
| My family and I have discussed and plan to develop a legal Power of Attorney for health care decisions in the event my health changes and I am unable to make decisions for myself. (Everyone in the family should have one!) |  |  |  |  |

**On a Scale of 1-10 how ready are you to make a change?**

**What is your number today? \_\_\_\_\_\_\_\_\_\_**

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**Family Quality Measurement**

**Care Coordinator,** this section is the opportunity for us to learn about the family’s experience with the Transition Readiness Checklist. If conducting the survey in-person or over the phone read each question and document the response from the Family Member. **Family Member**, please check ONE box for each question.

1) This checklist is helpful for planning my child's health care transition

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

2) You will be able to do everything that was discussed on the checklist

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

3) The health care transition is important to my child and family

* Strongly agree
* Agree
* Neither agree nor disagree
* Disagree
* Strongly disagree

**FOR Care Coordinator Use Only –** Please fill in the following information: The Care Coordinator’s name, the date the checklist was completed, the youth’s age and sex, the month they were identified, the method of administering the checklist and how the youth is classified by the Title V program. Once both sections are complete please enter into Survey Monkey Survey before placing this form in the youth’s chart.

|  |  |
| --- | --- |
| **Care Coordinator’s Name:** | **Child’s CHC ID:** |
| **Date Checklist Completed:** | **Youth Gender: Male  Female  Youth Age:** |
| **Circle this Youth’s Birth Month**  **JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC** | |
| **Classification: Check one box or both**  **Youth has Intellectual Disability  Youth has Special Health Care Need** | |
| **While completing the checklist, what was the highest level of interaction with the family? Check only one box**  **In-Person  Over the phone  By mail  Mailed the tool, no response after 6 months** | |