**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 Families**

**Care Coordinators,** please assist the family if they have questions, need help, a referral, or follow-up. **Family Member,** please take time to answer the questions below about your youth**.** Place an X in the most appropriate box. If answering “Someone else will have to do this,” name that person if possible. Compare your answers with your youth’s answers. You might be surprised what they know or want to learn. Work on a plan to increase health skills. Share with the medical team the skills that you are working on. It takes time and practice to learn and demonstrate these skills so the best time to start is today!

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health & Wellness 101****The Basic Skills** | **Does not need this** | **Yes can do this** | **Needs to learn how** | **Someone else will have to do this. Who?** |
| **KNOWLEDGE OF HEALTH ISSUES/DIAGNOSIS** |  |  |  |  |
| My child understands his/her health care needs and can explain these needs to others |  |  |  |  |
| My child understands how to take his/her medication and what the side effects may be. |  |  |  |  |
| My child can explain to others how our family’s customs and beliefs might affect health care decisions and medical treatments. |  |  |  |  |
| My child knows his/her health and wellness measures (weight, height, blood pressure, lab levels) |  |  |  |  |
| My child knows health symptoms that need quick medical attention. |  |  |  |  |
| My child knows about prescriptions, over the counter, and herbal medications and when to use them. |  |  |  |  |
| My child knows what to do in case he/she has a medical emergency. |  |  |  |  |
| **BEING PREPARED** |  |  |  |  |
| My Child carries his/her health insurance card every day. |  |  |  |  |
| My child carries his/her important health information with him/her 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** |  |  |  |  |
| My child calls for his/her own doctor appointments. |  |  |  |  |
| My child knows he/she has an option to see his/her doctor by him/herself. |  |  |  |  |
| Before a doctor’s appointment my child prepares written questions to ask. |  |  |  |  |
| My child tracks his/her own appointments, prescription refills, and expiration dates. |  |  |  |  |
| My child calls in his/her own prescriptions refills. |  |  |  |  |
| My child has a part in filing his/her medical records and receipts at home. |  |  |  |  |
| My child registers and pays his/her co-pays for medical visits. |  |  |  |  |
| My child helps monitor his/her medical equipment so it’s in good working condition (daily and routine maintenance) and knows who to contact if it needs to be fixed. |  |  |  |  |
| **After age 18** |  |  |  |  |
| My child and I have a plan so he/she can keep his/her healthcare insurance after he/she turns 18 and 26. |  |  |  |  |
| My child will be prepared to sign his/her own medical forms (HIPAA, consent for treatment, release of records). |  |  |  |  |
| My child and I have discussed and plan to develop a legal Power of Attorney for health care decisions in the event his/her health changes and he/she is unable to make decisions for him/herself. (Everyone in the family should have one!) |  |  |  |  |

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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** |