

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_



## Transition Checklist for Teens

This **Transition Checklist for Teens** is about the skills you need to learn to take care of your health when you become an adult. Your doctor or nurse will talk with you about the areas where you want help. Please complete this checklist by marking the box or boxes that describe you the best. If you do not understand a question, please ask your parent, nurse, or doctor for help.

ACCESSING HEALTH CARE - Skills and Abilities:	YES, I do	NO, I will learn	Someone will need to do this for me	N/A, Will not be needed	Need more info
△ Do you wear or carry a medical alert (list of allergies, conditions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
△ Do you speak up for yourself in your doctor's office?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
△ Do you help make health care decisions with your family or doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
△ Do you see your doctor without your family/parents in the room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know your rights to keep your health information private?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you call your doctor(s) on your own if you have a problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know how to schedule your own doctor appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you have an updated portable medical summary and/or care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you have an adult doctor (or a doctor for while you are at college)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MANAGING YOUR CONDITIONS AND TREATMENTS - Skills and Abilities:					
△ Do you know how to describe your own health conditions/disabilities and do you know how they affect your daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know the names of your medicines and why you take them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know what can happen if you skip your treatments or medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you almost always take your medicines correctly on your own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know when and how to fill your own prescriptions (knowing who prescribed and where to call, getting refills on time)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you use and take care of your own medical equipment and supplies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know when to call for routine checkups, urgent care, and when to go to the emergency room or call 9-1-1?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STAYING HEALTHY - Skills and Abilities:					
△ Do you know how to maintain a healthy lifestyle (diet, activity, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
△ Do you understand how smoking, drinking, and/or using drugs can affect your condition (worsen symptoms, react with your medicines)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know how your condition affects sexuality (the need for closeness, caring, and touch, sometimes involving sexual activity)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know what you'll do for birth control, safe sex, and reproductive concerns (genetics, pregnancy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INSURANCE - Skills and Abilities:					
□ Do you know how to use your health insurance benefits (co-pays, referrals)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know who to call for questions about your insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know how you will maintain health insurance as an adult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER AREAS OF TRANSITION - Skills and Abilities:					
□ Do you know what you will do after high school (job, more school, recreational options, volunteer, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know of resources that can help you to find adult services (job support, transportation, assistive technology, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
□ Do you know how your condition might affect your job choices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know what government benefits you might qualify for (SSI, SSDI, Health Benefits for Workers with Disabilities, Home & Community Based Services, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know about guardianship or power of attorney for health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know your options for housing as an adult (on your own, group home)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Do you know how to manage your money and pay your bills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

KEY:  ET  MT  LT

**Office Use:** The *Transition Checklist for Teens* can help the clinician assess readiness of the youth and family to transition to adult systems by evaluating the adolescent's current skill levels, identifying areas for education and practice prior to transition, and determining areas in which the patient will need continued support as an adult. This checklist has been coded with a symbol and color to help clinicians focus on developmentally appropriate skills. Clinicians should encourage younger teens to build skills in the areas shaded in purple or marked with  $\Delta$ ; middle teens should work on the areas shaded in yellow or marked with  $\square$ ; and the areas in green or marked with  $\circ$  are for teens/young adults who are about to transition.

$\Delta$  Early Transition

$\square$  Middle Transition

$\circ$  Late Transition

A checklist such as this can serve as a framework for both the adolescent and the physician to use in preparing and planning for transitioning. Measure progress by using the same tool at periodic intervals:

- Ask adolescents to complete the checklist every 12 to 24 months (12 is recommended)
- Review progress and recognize success
- Document results and update transition goals

<b>Office Use Only</b>	<b>Provider Notes:</b>
<p>Reviewed by: _____ Date: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	Empty space for provider notes

Materials supported through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, D70MC12840. Developed by the UIC - Division of Specialized Care for Children and the Illinois Chapter, American Academy of Pediatrics.