Transition Readiness Assessment for Youth (ALABAMA)

Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what you already know about your health and the areas that you think you need to learn more about. After you complete the form, compare your answers with the form your parent/caregiver has completed. Your answers may be different. We will help you work on some steps to increase your health care skills.

Date:

Name: Date of Birth:

Transition Importance and Confidence *On a scale of 0 to 10; please circle the number that best describes how you feel right now.*

How important is it to you to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health *Please check the box that applies to you right now.*	*Yes, I know this*	*I need to learn*	*Someone needs to do this… Who?*
I know my medical needs.	☐	☐	☐
I can explain my medical needs to others.	☐	☐	☐
I know my symptoms including ones that I quickly need to see a doctor for.	☐	☐	☐
I know what to do in case I have a medical emergency.	☐	☐	☐
I know my own medicines, what they are for, and when I need to take them.	☐	☐	☐
I know my allergies to medicines and medicines I should not take.	☐	☐	☐
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, and medical summary).	☐	☐	☐
I understand how health care privacy changes at age 19 when I am legally an adult.	☐	☐	☐
I can explain to others how my customs and beliefs affect my health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
I know or I can find my doctor's phone number.	☐	☐	☐
I make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know to show up 15 minutes before the visit to check in.	☐	☐	☐
I know where to go to get medical care when the doctor's office is closed.	☐	☐	☐
I have a file at home for my medical information.	☐	☐	☐
I have a copy of my current plan of care.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to get referrals to other providers.	☐	☐	☐
I know where my pharmacy is and how to refill my medicines.	☐	☐	☐
I know where to get blood work or x-rays if my doctor orders them.	☐	☐	☐
I have a plan so I can keep my health insurance after age 18 or older.	☐	☐	☐
My family and I have discussed my ability to make my own health care decisions at age 19.	☐	☐	☐

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Transition Readiness Assessment (ALABAMA)
for Parents/Caregivers
Six Core Elements of Health Care Transition 2.0

Please fill out this form to help us see what your child already knows about his or her health and the areas that you think he/she needs to learn more about. After you complete the form, compare your answers with the form your child has completed. Your answers may be different. We will help you work on some steps to increase your child's health care skills.

Date:

Name: Date of Birth:

Transition Importance and Confidence

On a scale of 0 to 10; please circle the number that best describes how you feel right now.

How important is it for your child to prepare for/change to an adult doctor before age 22?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

How confident do you feel about your child's ability to prepare for/change to an adult doctor?

0 (not)	1	2	3	4	5	6	7	8	9	10 (very)

My Health — ***Please check the box that applies to your child right now.***	*Yes, he/she knows this*	*He/she needs to learn*	*Someone needs to do this… Who?*
My child knows his/her medical needs.	☐	☐	☐
My child can explain his/her medical needs to others.	☐	☐	☐
My child knows his/her symptoms including ones that he/she quickly needs to see a doctor for.	☐	☐	☐
My child knows what to do in case he/she has a medical emergency.	☐	☐	☐
My child knows his/her own medicines, what they are for, and when he/she needs to take them.	☐	☐	☐
My child knows his/her allergies to medicines and medicines he/she should not take.	☐	☐	☐
My child carries important health information with him/her every day (e.g. insurance card, allergies, medications, emergency contact information, and medical summary).	☐	☐	☐
My child knows he/she can see a doctor alone as I wait in the waiting room.	☐	☐	☐
My child understands how health care privacy changes at age 19.	☐	☐	☐
My child can explain to others how his/her customs and beliefs affect health care decisions and medical treatment.	☐	☐	☐
Using Health Care			
My child knows or can find his/her doctor's phone number.	☐	☐	☐
My child makes his/her own doctor appointments.	☐	☐	☐
Before a visit, my child thinks about questions to ask.	☐	☐	☐
My child has a way to get to his/her doctor's office.	☐	☐	☐
My child knows to show up 15 minutes before the visit to check in.	☐	☐	☐
My child knows where to go to get medical care when the doctor's office is closed.	☐	☐	☐
My child has a file at home for his/her medical information.	☐	☐	☐
My child has a copy of his/her current plan of care.	☐	☐	☐
My child knows how to fill out medical forms.	☐	☐	☐
My child knows how to get referrals to other providers.	☐	☐	☐
My child knows where his/her pharmacy is and how to refill his/her medicines.	☐	☐	☐
My child knows where to get blood work or x-rays if his/her doctor orders them.	☐	☐	☐
My child has a plan to keep his/her health insurance after age 18 or older.	☐	☐	☐
My child and I have discussed his/her ability to make his/her own health care decisions at age 19.	☐	☐	☐
My child and I have discussed a plan for supported decision-making, if needed.	☐	☐	☐

Medical Summary and Emergency Care Plan

Six Core Elements of Health Care Transition 2.0

This document should be shared with and carried by youth and families/caregivers.		
Date Completed:		Date Revised:
Form completed by:		
Contact Information		
Name:		Nickname:
DOB:		Preferred Language:
Parent (Caregiver):		Relationship:
Address:		
Cell #: Home #:		Best Time to Reach:
E-Mail:		Best Way to Reach: Text Phone Email
Health Insurance/Plan:		Group and ID #:
Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		
Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Special Concerns for Disaster:		

Allergies and Procedures to be Avoided	
Allergies	Reactions
To be avoided	Why?
☐ Medical Procedures:	
☐ Medications:	
Diagnoses and Current Problems	
Problem	Details and Recommendations
☐ Primary Diagnosis	
☐ Secondary Diagnosis	
☐ Behavioral	
☐ Communication	
☐ Feed & Swallowing	
☐ Hearing/Vision	
☐ Learning	
☐ Orthopedic/Musculoskeletal	
☐ Physical Anomalies	
☐ Respiratory	
☐ Sensory	
☐ Stamina/Fatigue	
☐ Other	

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Six Core Elements of Health Care Transition 2.0

Medications					
Medications	Dose	Frequency	Medications	Dose	Frequency

Health Care Providers				
Provider	Primary and Specialty	Clinic or Hospital	Phone	Fax

Prior Surgeries, Procedures, and Hospitalizations	
Date	
Date	
Date	
Date	
Date	

Baseline
Baseline Vital Signs: Ht Wt RR HR BP
Baseline Neurological Status:

Most Recent Labs and Radiology		
Test	Date	Result
EEG		
EKG		
X-Ray		
C-Spine		
MRI/CT		
Other		
Other		

Equipment, Appliances, and Assistive Technology			
☐Gastrostomy	☐Adaptive Seating		☐Wheelchair
☐Tracheostomy	☐Communication Device		☐Orthotics
☐Suctions	Monitors:		☐Crutches
☐Nebulizer	☐Apnea	☐O2	☐Walker
	☐Cardiac	☐Glucose	
☐Other			

Medical Summary and Emergency Care Plan

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School and Community Information		
Agency/School	Contact Information	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

Special information that the youth or family wants health care professionals to know

Please attach the immunization record to this form.

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