

Sample Transition Readiness Assessment for Youth

Please fill out this form to help us see what you already know about your health, how to use health care, and the areas you want to learn more about. If you need help with this form, please ask your parent/caregiver or doctor.

Preferred name _____ Legal name _____ Date of birth _____ Today's date _____

TRANSITION IMPORTANCE & CONFIDENCE *Please circle the number that best describes how you feel now.*

The transfer to adult health care usually takes place between the ages of 18 and 22.

How important is it to you to move to a doctor who cares for adults before age 22?

0 ○ | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ | 6 ○ | 7 ○ | 8 ○ | 9 ○ | 10 ○
not _____ *very*

How confident do you feel about your ability to move to a doctor who cares for adults before age 22?

0 | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5 ○ | 6 ○ | 7 ○ | 8 ○ | 9 ○ | 10 ○
not _____ *very*

MY HEALTH & HEALTH CARE *Please check the answer that best applies now.*

	NO	I WANT TO LEARN	YES
I can explain my health needs to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to ask questions when I do not understand what my doctor says.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my allergies to medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my family medical history.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I talk to the doctor instead of my parent/caregiver talking for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I see the doctor on my own during an appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when and how to get emergency care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where to get medical care when the doctor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry important health information with me every day (e.g., insurance card, emergency contact information).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know that when I turn 18, I have full privacy in my health care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know at least one other person who will support me with my health needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to find my doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to make and cancel my own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a way to get to my doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to get a summary of my medical information (e.g., online portal).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to fill out medical forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to get a referral if I need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what health insurance I have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what I need to do to keep my health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I talk with my parent/caregiver about the health care transition process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MY MEDICINES *If you do not take any medicines, please skip this section.*

I know my own medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know when I need to take my medicines without someone telling me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to refill my medicines if and when I need to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHICH OF THE SKILLS LISTED ABOVE DO YOU MOST WANT TO WORK ON?
