

TRANSITION CHECKLIST: Ages 12-15

Name: _____ Date of Birth: ____/____/____

Today's Date: _____ Name of person completing form: _____

Relationship to Patient: self ____ parent(s) ____ CF Clinic staff ____

Please use the following scale to rate the **FREQUENCY** of each item. (For parents completing this form, use the scale as it applies to your **observations** of your child):

1= Does Not Apply 2= Never 3= Sometimes 4=Often 5= Always

CF HEALTH KNOWLEDGE:	
I can accurately describe my diagnosis.	1 2 3 4 5
I can accurately describe the symptoms of my illness.	1 2 3 4 5
I can describe my daily care routine.	1 2 3 4 5
I know my medications, the amounts and times I take them.	1 2 3 4 5
I know what each medication is for.	1 2 3 4 5
I know emergency medical phone numbers.	1 2 3 4 5
I know the "warning signs" that mean I should call the doctor.	1 2 3 4 5
INDEPENDENT HEALTHCARE ACTIONS:	
I answer at least one of my health care provider's questions myself.	1 2 3 4 5
I ask my health care providers at least one of my own questions.	1 2 3 4 5
I meet with my health care providers during clinic visits by myself at least part of the time.	1 2 3 4 5
I take charge of my daily health care routine without reminders.	1 2 3 4 5
I schedule my own clinic/ doctor's appointments.	1 2 3 4 5
I tell my parents when I need to have them order more medications.	1 2 3 4 5
I tell my parents or other adults about any unusual changes in my health.	1 2 3 4 5
I help my parents remember my daily care routine.	1 2 3 4 5
LIFESTYLE ISSUES:	
I know why smoking, alcohol and drug use are not good for me.	1 2 3 4 5
I engage in regular physical activity.	1 2 3 4 5
I get enough rest and sleep.	1 2 3 4 5
I know what and how much to eat and drink to be healthy.	1 2 3 4 5
SOCIAL RELATIONSHIPS AND WELL-BEING:	
I have friends and get together with them at least once a week.	1 2 3 4 5
I know when I feel stressed out, nervous, angry or down.	1 2 3 4 5
I talk with friends, family or other trusted people about problems when I need to.	1 2 3 4 5
I know when and how to ask for a counselor's help with different problems.	1 2 3 4 5
I am realistic about my health.	1 2 3 4 5
I have thought about the risks and benefits of discussing my health with different people.	1 2 3 4 5
I have thought about how to discuss my health with different people.	1 2 3 4 5
I enjoy my life and generally have a positive outlook.	1 2 3 4 5

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SEXUAL HEALTH:	
I understand how reproduction works.	1 2 3 4 5
I know where and how to seek more information on reproduction.	1 2 3 4 5
I understand how to prevent pregnancy.	1 2 3 4 5
I understand how to prevent sexually transmitted diseases.	1 2 3 4 5
EDUCATIONAL AND VOCATIONAL PLANNING:	
I have ideas about what I'd like to do after High School.	1 2 3 4 5
I have talked with my parents/ school counselor/ teacher/ doctor or nurse about plans for college and/ or employment.	1 2 3 4 5
I have talked with my parents/ school counselor/ teacher/ doctor or nurse about volunteer work I might like to do.	1 2 3 4 5
I understand the importance of a healthy work environment.	1 2 3 4 5
I have attended a school 504 meeting.	1 2 3 4 5
I know my rights under the ADA and Sect. 504.	1 2 3 4 5
FINANCIAL AND PRACTICAL NEEDS:	
I know the name of my health insurance.	1 2 3 4 5
I know how health insurance works.	1 2 3 4 5
I know how to find my health insurance identification number.	1 2 3 4 5
I manage my own money. (I have a bank account, I stick to a budget, etc.)	1 2 3 4 5

What are your **top 3 concerns** about any area of your (your child's) life? :

1. _____
2. _____
3. _____

How would you like to handle these concerns? : _____

What are your strengths? : _____

What would you like to do better? : _____

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Information You Would Like to Have:

- Medical information
- Financial assistance resources
- Insurance
- Disclosing CF
- Disability rights
- Employment
- Education
- Financial aid for college
- Lung Transplantation
- Other
- Advanced Directives
- Fertility
- Genetic counseling/ testing
- CF websites
- Sexuality
- Adult CF Clinic
- Nutrition
- Infection prevention
- Vocational counseling

For the above, please describe specifics: _____

PLAN:

This Checklist completed: ____/____/____

Next Checklist to be completed: ____/____/____

Patient/ Guardian Signature: _____

Social Worker Signature: _____