



LAST NAME (FIRST)

Transition Readiness Checklist for PATIENTS

Good 2 Go Transition Program

Health Condition: _____

Division of Adolescent Medicine

Clinic: _____

DATE OF BIRTH SEX MRN

YY - MM - DD

ADDRESS

Instructions: Please complete the following checklist using the scales below. There are no right or wrong answers. Try to answer every question. There is a section to add comments on the next page.

IMPRINT OR ENTER DETAILS BY HAND

		I never do this (someone does this for me)	I rarely do this (but I'm starting to try)	I sometimes do this and sometimes don't	I do this often	I always do this (I'm there!)	Does not apply to me
	For each of the following statements, select one response that best suits you:						
1.	I can describe my condition and explain my special health-care needs to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
2.	I am in charge of preparing and taking my medications and/or treatments on my own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
3.	I take part in health-care discussions about me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
4.	I plan how to take care of my own health needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
5.	I organize and keep track of my health information (for example, appointments, medications, test results).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
6.	I use people outside of my family (for example, friends, community members) to support me in managing my condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
7.	I can get myself to health-care appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
8.	I spend time alone with my health-care provider at each visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
9.	I talk to my health-care provider about the impact of my condition on my sexual functioning and health (for example, sexually transmitted infections, protection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
10.	I talk to my health-care provider about how my condition is affected by the use of tobacco, alcohol and drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
11.	I speak up for myself and tell others what I need during health-care visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
12.	I talk to my health-care provider about ways to manage stress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
13.	I talk to my health-care provider about how my health condition affects my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A

		I have no idea	I think I know a bit about this (but need to learn a lot more)	I know some of this (but need to learn some more)	I know most of this (but still need to learn more)	I know all about this (I'm there!)	Does not apply to me
14.	I know the names of my medications and/or treatments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
15.	I know what my medications and/or treatments are for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
16.	I know how my medications and/or treatments are paid for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
17.	I know what my health condition may bring in the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
18.	I know I have the right to get information about my health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
19.	I know the kinds of health-care providers I will need to see as an adult.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
20.	I understand how my condition will affect the way I develop through puberty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
21.	When I get sick, I know how to get the help I need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
22.	I know how to schedule a health-care appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N/A
For each of the following statements, select one response that best suits you:							
23.	I have supports (for example, family, friends or community members) available to help me in managing my condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
24.	I hang out with friends who support me or are good to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25.	I am involved in clubs, groups, sports or activities that I like.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
26.	I am attending school regularly or have a job.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Please include any comments or questions about any of the items in the space below: