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 **FRQUENCY** 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.	
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

Name: Date of Birth:

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? : _____
_____
_____
_____

Name: _____ Date of Birth: _____

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: _____