

Sample Transition Readiness Assessment for Parents/Caregivers

Please fill out this form to help us see what your child already knows about their health and the areas you think they want to learn more about. After you complete the form, you can ask your child to share their answers from their completed form, and you can compare them. Your answers may be different. Your child’s doctor will help you work on steps to increase your child’s health care skills.

Youth name _____ Parent/Caregiver name _____ Youth date of birth _____ Today’s date _____

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

How important is it for your child to manage their own health care?

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

How confident do you feel about your child's ability to manage their own health care?

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

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

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

MY CHILD’S MEDICINES *If your child does not take any medicines, please skip this section.*

My child knows their own medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows when they need to take their medicines without someone telling them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to refill their medicines if and when they need to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHICH OF THE SKILLS LISTED ABOVE DOES YOUR CHILD MOST WANT TO WORK ON?



How to Score the Transition Readiness Assessment for Parent/Caregivers *(For Office Use Only)*

The purpose of the transition readiness assessment is to begin a discussion with youth and parents/caregivers about health-related skills. Scoring is optional and can be used to follow individual progress on gaining these skills, not to predict successful transition outcomes.

This scoring sheet can be filled out to score a parent/caregiver's completed transition readiness assessment or it can be used as a scoring guide to refer to when marking the score on their completed assessment.

Each response can be converted to a score of 0 (No), 1 (They want to learn), or 2 (Yes). Because not all youth are taking medicines, numbers in “My Child’s Health and Health Care” and “My Child’s Medicines” should be calculated separately.

MY CHILD'S HEALTH & HEALTH CARE <i>Please check the answer that best applies now.</i>	NO	THEY WANT TO LEARN	YES
My child can explain their health needs to others.	0	1	2
My child knows how to ask questions when they do not understand what their doctor says.	0	1	2
My child knows their allergies to medicines.	0	1	2
My child knows our family medical history.	0	1	2
My child talks to the doctor instead of me talking for them.	0	1	2
My child sees the doctor on their own during an appointment.	0	1	2
My child knows when and how to get emergency care.	0	1	2
My child knows where to get medical care when the doctor's office is closed.	0	1	2
My child carries important health information with them every day (e.g., insurance card, emergency contact information).	0	1	2
My child knows that when they turn 18, they have full privacy in their health care.	0	1	2
My child knows at least one other person who will support them with their health needs.	0	1	2
My child knows how to find their doctor's phone number.	0	1	2
My child knows how to make and cancel their own doctor appointments.	0	1	2
My child has a way to get to their doctor's office.	0	1	2
My child knows how to get a summary of their medical information (e.g., online portal).	0	1	2
My child knows how to fill out medical forms.	0	1	2
My child knows how to get a referral if they need it.	0	1	2
My child knows what health insurance they have.	0	1	2
My child knows what they need to do to keep their health insurance.	0	1	2
My child and I talk about the health care transition process.	0	1	2
MY CHILD'S MEDICINES <i>If your child does not take any medicines, please skip this section.</i>			
My child knows their own medicines.	0	1	2
My child knows when they need to take their medicines without someone telling them.	0	1	2
My child knows how to refill their medicines if and when they need to.	0	1	2

My Child's Health & Health Care Total Score: _____ /40

My Child's Medicines Total Score: _____ /6