

TRANSITIONING TO INDEPENDENCE: HOW READY ARE YOU?

Young people can take care of their own health conditions or disabilities in a variety of ways. Shriners Hospital would like to help you build the skills you need to make a successful transition to adult care and independent living. Please take a few moments to answer the questions on the front and back of this page. Then please turn this in to your nurse. Thank you.

A. STAYING HEALTHY

1.	I have a doctor or clinic that I go to when I am sick or need a check-up.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
2.	My immunizations are up to date.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	I know my medical insurance numbers, or carry the information in my wallet.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	I know about my medical insurance coverage.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	I call to schedule my own medical and dental appointments.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	I keep a calendar of doctor and dentist appointments.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	I can get my medical records, diagnosis information, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	I know how to hire and manage a personal care attendant, if I need one.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	I know emergency telephone numbers, or carry information in my wallet.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	I know how to find and contact appropriate community support programs.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
11.	I know how to get transportation to my medical appointments, school, and job.	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
12.	I know how drugs, alcohol, and tobacco products affect my health.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
13.	I know how to prevent unplanned pregnancy and sexually transmitted diseases.	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Any questions or comments?

B. KNOWLEDGE OF YOUR HEALTH CONDITION

1.	I can describe my medical condition or disability.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
2.	I understand how my condition can affect my daily life.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	I know the "danger signs" of my condition and when to seek medical care.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	I am responsible for taking my own medications.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	I know my medications, what they do, and their side effects.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	I know when, how much, and why I take medications (prescription and over-the-counter, like Tylenol).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	I can get my prescriptions refilled.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	I can get the medication, therapy, supplies, and equipment I need.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	I am responsible for doing my own treatments.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any questions or comments?

Almost finished. Please turn this over and answer the questions on the back too.

C. EDUCATION AND WORK

1.	I go to school.	{ Yes	{ No
2.	My school works with me to care for my special needs.	{ Yes { No	{ Not Applicable
3.	I participate in Individual Education Plan (IEP) meetings at school.	{ Yes { No	{ Not Applicable
4.	I plan to graduate from high school.	{ Yes	{ No
5.	I know what I need to do to get into college, vocational training, or get a good job.	{ Yes	{ No
6.	I have a volunteer job.	{ Now { Used to	{ Never
7.	I get paid for a part-time or full-time job.	{ Now { Used to	{ Never
8.	I know what I would like to do when I become an adult.	{ Yes	{ No

Any questions or comments?

D. ADULT HEALTH CARE

1.	I have identified who will be my doctor when I leave Shriners Hospital.	{ Yes	{ No
2.	I have made an appointment with my adult health care provider.	{ Yes	{ No
3.	I have already had an appointment with my adult health care provider.	{ Yes	{ No
4.	I have a way to pay for my health care as an adult.	{ Yes	{ No

Any questions or comments?

Now, please sign below and turn this in to your nurse. Thank you.

Your Signature _____ Your Age _____

Today's Date _____