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It's Time To Transition!

A Workbook for Young Adults, Their Families, and Their Medical Providers

Shared with Mountain States Regional Collaborative 2006

This Workbook Belongs To:

Post a picture of yourself on this page if you wish.

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It's Time to Transition!

This phrase strikes fear into the hearts of most parents and providers of medical care for young adults with special health care needs. My experience has been that most young adults are both excited and energized by this process.

The goal of this workbook is to organize the medical transition process into a smooth, successful move from pediatric focused to adult focused health care. Please feel free to use these pages as they seem to make sense for you. I would appreciate any feedback/suggestions you have as you navigate through this process. This workbook is not meant to substitute for other transition resources you may have available to you from the school system or community. The focus is on medical transition. Transition is a comprehensive process involving all facets of your life. As you think about what items to include in this workbook keep in mind that the average adult doctor is limited on time and will want to see a summary of health information, not necessarily all the details. That information can be requested at a later time after transition has happened, if necessary.

This workbook is really about you! The final decisions about what to include in these pages should ultimately be your decision. You should discuss your choices with your parents and current medical providers to make sure all the information is as complete and correct as possible. The average successful medical transition takes about a year. There is no rush, so be thoughtful about what you include as you walk through these pages. Most of all have fun! This is a great opportunity to learn more about your health and how it can affect the rest of your life.

Good Luck and Congratulations!!!

Laura Pickler, MD
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My Story

My hobbies are:

_____
_____
_____

My favorite things are:

_____
_____
_____

I am unique because (Include special health care needs):

_____
_____
_____

The activities I am involved in are:

_____
_____
_____
_____

In five years I hope to:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Use the back of this page to write other interesting information about yourself that you would like for your new doctor to know. Do you have any fears or concerns about the transition process?

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Family Information

My name: _____ Nickname(s): _____
Date of Birth: _____ Social Security Number: _____
Address: _____
Phone number: _____

~~~~~~

Emergency Contact Person:_____
Daytime Phone: _____ Evening Phone: _____
Relationship to me: _____
Address: _____

~~~~~~

Guardian (if "self" please indicate) _____
Daytime Phone: _____ Evening Phone: _____
Relationship to me: _____
Address: _____

~~~~~~

Parent's Names: _____
Daytime Phone: _____ Evening Phone: _____
Address: _____
Contact in an Emergency? _____

~~~~~~

Siblings Names: _____ _____
_____ _____
_____ _____
Contact in an Emergency? _____
Provide Contact Information: _____

~~~~~~

People who live with me:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
~~~~~~

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Community Contact Information:

School Name: _____
Grade or year in school: _____
School Phone: _____ Contact Person: _____
Academic Counselor: _____ Phone: _____

~~~~~~

Department of Health and Human Services Case Number: _____
Case Manager/Title: _____
Address: _____
Daytime phone: _____ Evening Phone: _____
Fax: _____

~~~~~~

Other Case Management: _____
Case Manager/Title: _____
Address: _____
Daytime phone: _____ Evening Phone: _____
Fax: _____

~~~~~~

Durable Medical Equipment Company: _____
Case Manager/Title: _____
Address: _____
Daytime phone: _____ Evening Phone: _____
Fax: _____

~~~~~~

Church or Religious Community: _____
Daytime Phone: _____ Evening Phone: _____
Address: _____
Contact in an Emergency? _____

~~~~~~

Other Important Personal or Family Information Please Continue on the back of this page.
~~~~~~

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Household Emergency Information

My Address: _____
Directions to my house:
_____
_____
_____
_____

~~~~~~

Fire Department Number: 911 or _____
Police Department Number: 911 or _____
Ambulance: 911 or _____
Poison Control Hotline: _____

~~~~~~

Fire Escape Plan :
_____
_____
_____
_____

~~~~~~

Check smoke alarms monthly!

Check fire extinguishers monthly!
~~~~~~

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Care Plan for Behavior Disorders

Crisis Hotline: _____ Case Manager Phone: _____
Family contact person: _____ Phone: _____

~~~~~~

What behavior pattern is typical for this individual? Include affect, seasonal changes etc.

_____
_____
_____
_____
_____

~~~~~~

Worrisome Behavior to Watch for:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Intermediate Dangerous Behavior:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Dangerous Behavior:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Extremely Dangerous Behavior: **CALL 911 or CRISIS HOTLINE**

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Care Plan for Medical Disorders

Physician Call Center Number: _____ Case Manager Phone: _____
Family contact person: _____ Phone: _____

~~~~~~

What medical symptoms are typical for this individual? Include affect, behavioral problems, physical symptoms etc. of frequently occurring illnesses.

_____
_____
_____
_____
_____

~~~~~~

Worrisome Symptoms to Watch for:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Worsening Symptoms:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Dangerous Symptoms:

_____
_____
_____

Action Plan:

1. _____
2. _____
3. _____

Life Threatening Situations: **CALL 911**

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Medical Summary Reflecting the Most Recent Complete Physical Examination

Insert a copy of the most recent history and physical exam done by your primary care doctor. If you have several specialists who follow you closely include their most recent report summarizing your care.

To the medical provider:

- ***Have you thought about gynecological issues such as contraception?***
- ***Are there any other concerns that need to be discussed dealing with family planning or sexuality?***
- ***Are there any serious ongoing issues that are in the process of being evaluated or any recent changes to medicines or therapies?***
- ***Are there any specific tips for staying healthy that the young adult would benefit from? List them as part of your report.***

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Current Medication Summary Sheet

Drug Name	Date Started	Date Ended	Dosage	Frequency Given	Reason For Taking	Observed Side Effects

Medications That Didn't Work

Name of Drug	Date Started	Date Ended	Dosage/Frequency	Reason for Stopping

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Immunization and Preventable Disease History

Insert a copy of your immunization record here.

Disease History:
Chicken Pox _____
Hepatitis B _____
Hepatitis A _____

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Doctor Contact Information

Primary Care Provider:____
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

Counselor/Therapist: ____
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

Specialist Provider: _________________________ **Specialty:** ______________
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

Specialist Provider: _________________________ **Specialty:** ______________
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

Specialist Provider: _________________________ **Specialty:** ______________
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

Specialist Provider: _________________________ **Specialty:** ______________
Address: ____
Phone:_________________________ Fax: ____________________________
Emergency/After Hours Number: _______________________________________

~~~~~~

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Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Specialist Provider: ______________________________ Specialty: __________________
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

~~~~~~

Dentist: ____
Address: ____
Phone:_______________________________ Fax: ___________________________________
Emergency/After Hours Number: ____

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Physical Therapist: _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

Occupational Therapist: _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

Speech-Language Pathologist: _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

Eye Care Provider : _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

Other: _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

Other: _____
Address: _____
Phone:_____ Fax: _____
Emergency/After Hours Number: _____

~~~~~~

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Mental Health Care Summary Sheet

Date: _____ Contact number: _____
Provider: _____
Reason for visit:
_____
_____

Diagnosis: Axis I _____
Axis II _____
Axis III _____
Axis IV _____

Treatment Goal : _____

Treatment Method:
_____
Follow Up Appointment: _____

To do List:

_____
_____
_____
_____

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?

_____

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Mental Health Testing and Monitoring

Insert copies of any psychological testing results done to date in this section. If applicable include the most recent Ames test for psychotropic medication monitoring.

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Medical Care Summary Sheet

Date: _____ Contact Number: _____
Provider: _____ Specialty: _____
Reason for visit:
_____
_____

Diagnosis:
_____
_____

Treatment : _____

Follow Up Appointment: _____

To Do List:

_____
_____
_____
_____
_____

Do you anticipate transition from your care to another provider for adult services? If so, do you have an adult provider to refer this patient to?

_____

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Insurance Information/Considerations
Include a copy of your Insurance Card and Social Security Card in this Section

Ask Yourself:

- Do I need a referral?
- Does my insurance change with age or school status?
- Does my insurance change with employment status?
- If my insurance changes, are there certain services that will be less available after I reach a certain age?

IF YOU CAN'T ANSWER THE QUESTIONS ABOVE THE TIME TO FIND OUT ABOUT YOUR COVERAGE IS NOW!!

~~~~~~

Primary Insurance: _____ Plan number: _____
Group number: _____ ID number: _____
Subscriber's name: _____
Subscriber's Social Security Number: _____
Mailing address: _____
Phone: _____ Fax: _____

~~~~~~

Secondary Insurance: _____ Plan number: _____
Group number: _____ ID number: _____
Subscriber's name: _____
Subscriber's Social Security Number: _____
Mailing address: _____
Phone: _____ Fax: _____

~~~~~~

Other Insurance: _____ Plan number: _____
Group number: _____ ID number: _____
Subscriber's name: _____
Subscriber's Social Security Number: _____
Mailing address: _____
Phone: _____ Fax: _____

~~~~~~

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Other Transition Areas To Consider:

Other questions to answer are:

- **Do I need a vocational rehabilitation advisor to transition from school to work? If yes…**

Name of Contact: _____
Phone number: _____
Date Contact Initiated: _____
First Meeting Date: _____
TO DO List Prior to the First Meeting:
_____
_____
_____
_____
_____

- **Do I need an independent living advisor to transition from home to adult living? If yes…**

Name of Contact: _____
Phone number: _____
Date Contact Initiated: _____
First Meeting Date: _____
TO DO List Prior to the First Meeting:
_____
_____
_____
_____
_____

- **Do I need any additional help transitioning from secondary school to college or technical school? If yes…**

Name of Contact: _____
Phone number: _____
Date Contact Initiated: _____
First Meeting Date: _____
TO DO List Prior to the First Meeting:
_____
_____
_____
_____

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- **Do I need help managing my transportation needs in order to meet my transition goals? If yes…**

Name of Social Worker: _____
Phone number: _____
Date Contact Initiated: _____
First Meeting Date: _____
TO DO List Prior to the First Meeting:
_____
_____
_____
_____

- **Do I have any other needs that need to be met prior to implementing my transition plan? If yes list them here and talk to your doctor.**

- **Make a list of important "Keys To Staying Healthy" and post them here.**

Congratulations!!
You're Ready To Transition!