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.

This notebook is for personal use only. Any duplication should not be without the expressed written consent of the author.
This work was supported by a grant from Champions for Progress # 2580410 and AAP/CATCH # 2580398.
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
Pickler.laura@tchden.org
Table of Contents

Important Information
   Family Contact Information
   Emergency Information
   At a Glance Info for Wallet or Purse
   Emergency Care Plans
   General Medical Information
   Immunization Information
   Insurance Information/Considerations
   Doctor Contact Information

Me, Myself and I
   My Story

Current Medical Info
   Doctor Care Notes
   Mental Health Care Notes
   Mental Health Testing and Monitoring

History
   Medical Notes Over a Year Old
   Diagnostic Info or Test Results Worth Keeping

Other Transition Areas
   Things To Consider
   Resources
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?
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: __________________________
Name: ___________________________ Relationship: __________________________
Name: ___________________________ Relationship: __________________________
Name: ___________________________ Relationship: __________________________
Name: ___________________________ Relationship: __________________________
Name: ___________________________ Relationship: __________________________
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.
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!
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
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
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.*
# Current Medication Summary Sheet

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Date Started</th>
<th>Date Ended</th>
<th>Dosage</th>
<th>Frequency Given</th>
<th>Reason For Taking</th>
<th>Observed Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# Medications That Didn’t Work

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Date Started</th>
<th>Date Ended</th>
<th>Dosage/Frequency</th>
<th>Reason for Stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Immunization and Preventable Disease History

Insert a copy of your immunization record here.

Disease History:
Chicken Pox ___________________
Hepatitis B ____________________
Hepatitis A ____________________
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: ____________________________________________
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: ____________________________________________
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: __________________________________________
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?
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.*
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?
________________________________________________________________________
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: _______________________________
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:

  __________________________________________________________________________

  __________________________________________________________________________

  __________________________________________________________________________
• 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!