CHECKLIST FOR CLINICIANS

Use this checklist to help prepare young people with chronic conditions for transition

- ☐ Start early - Identify young people aged 14 years and older
- ☐ Complete the transition readiness checklist with young person and/or with parents/carers
- ☐ Meet with the young person and their parents/carers to plan their future health care and discuss any worries about leaving paediatric health services and/or starting adult health services
- ☐ Become informed about transition and what services and resources are available
- ☐ Ensure the young person has a trusted GP before they leave the paediatric health system
- ☐ Start to address the young person first in consultations and encourage them to ask questions
- ☐ See the young person on their own for part of the consultations if appropriate.
- ☐ Take every opportunity to educate the young person to learn about their chronic condition and aspects of their care so that they can manage independently, to the best of their ability
- ☐ Complete a HEEADSSS assessment to identify any psychosocial issues which may impact on compliance and adherence
- ☐ Develop a transition plan with the young person
- ☐ Provide the young person with emergency contact numbers and a care plan
- ☐ Once the young person turns 14 copy them and their GP into all clinical correspondence
- ☐ Discuss what the young person can expect in adult health services including how to make appointments, how to get there, having their own Medicare card etc.
- ☐ Identify with the young person where they will be referred to in the adult health service
- ☐ Encourage the young person to keep copies of their clinic letters and health record
- ☐ Refer young person to Trapeze or ACI Transition Care Coordinators. They can assist you to complete transition plans and coordinate care. Contact the service if you have transition concerns or need further information
- ☐ Provide young people with a copy of the young person checklist

TICK THE BOXES