

Use this checklist to identify skills the young person already has, and those areas where you may need to help them to prepare for the move to new services.

| **Goal** | **Yes** | **Not Yet** | **Notes** |
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| BUILDING INDEPENDENCE | | | |
| Start preparing for the move when the young person is between 12–15 years old (*Transition Stage 4*). |  |  |  |
| Address the young person first in consultations, before their family/caregivers. Encourage the young person to ask questions. Do this during the first half of the consultation, when their attention is likely to be most focused. |  |  |  |
| See the young person on their own for part of the consultation. |  |  |  |
| Coach the young person to learn about their condition and care so that they can manage autonomously, to the best of their ability. |  |  |  |
| Do a psychosocial assessment (e.g. HEEADSSS) to identify any issues which may impact on ability to follow their care plan. |  |  |  |
| When the young person turns 15, copy them and their general practitioner (GP) into all clinical correspondence. |  |  |  |
| Encourage the young person to keep copies of their clinic letters and health record. |  |  |  |
| Discuss My Health Record with the young person. |  |  |  |
| Direct the young person to good online sources of information about their condition. |  |  |  |
| PREPARING FOR THE MOVE | | | |
| Find a key health professional to help the young person throughout the transition process. This may be a GP, nurse navigator, peer worker, or relevant allied health professional. |  |  |  |
| Identify the adult services that the young person will need and let the services know the young person will be transitioning into their care. |  |  |  |
| Complete the ***Healthcare Skills Review for Older Adolescents and Young Adults*** (see Moving on Up) with young person and their family/caregiver. |  |  |  |
| Meet with the young person and their family/caregiver to explain the transition process, plan their future health care and discuss any worries about leaving paediatric health services and starting new health services. |  |  |  |
| Work with the young person to develop the Individual Transition Care Plan (see ***Moving on Up***) including goals and timelines. |  |  |  |
| Learn about transition (see ***Moving on Up***) and the services and resources that are available, including peer support and social networking. |  |  |  |
| Provide the young person with emergency contact numbers and a care plan. |  |  |  |
| Tell the young person where they will be referred to in the new health service. |  |  |  |
| Discuss what the young person can expect in the new health service, including how to make appointments and how to get there. |  |  |  |
| Check if the young person has their own Medicare card. If they don’t, tell them how to apply for one. |  |  |  |
| If relevant, inform the young person and their family how to apply for NDIS eligibility. |  |  |  |

| **Goal** | **Yes** | **Not Yet** | **Notes** |
| --- | --- | --- | --- |
| BEFORE, DURING AND AFTER THE MOVE | | | |
| Set a start date for formal transition—make the first appointment with the new service. |  |  |  |
| Introduce the young person to relevant people in the new health service. This can be done by email or over the phone. Ask the new service to contact the young person so they become familiar with each other. |  |  |  |
| Make sure your communication with the new care team is transparent and timely. |  |  |  |
| Discuss with the young person and the new service where the young person should go for any acute health problems (including hospitalisations) during the transition period. |  |  |  |
| Set a transition completion date with the young person and the new service, after which any hospitalisation should be to adult hospital services. |  |  |  |
| Contact the young person within 3 months of the transition date to check if all the new services are in place. If there are gaps in service, contact the new providers to facilitate service delivery to the young person and their carer. |  |  |  |