**AST TRANSITION READINESS ASSESSMENT TOOL**

**LATE TRANSITION (17 YEARS and older)**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  | **DOMAINS** | **COMMENTS** | **SCORE** |
| --- | --- | --- | --- |
| **MY TRANSPLANT** | | | |
| 1. | Why did you need a transplant? What is/was the name of your disease/condition? |  | 2 – 1 – 0 - NA |
| 2. | Does having a transplant affect your daily life? *Prompts: Can you give me an example? Can you walk me through how you typically take care of yourself because you have had a transplant?* |  | 2 – 1 – 0 - NA |
| 3. | What is rejection? *Prompts: What does your health care provider look for if he/she thinks you are having rejection? If you had rejection, what would happen?* |  | 2 – 1 – 0 - NA |
| 4. | Why do you need to get your labs checked routinely (every month, every 3 months, etc.)? |  | 2 – 1 – 0 - NA |
| 5. | Do you have a personal health record (hard copy or electronic)? If not, how could you get one? Why would it be helpful to have a personal health record? |  | 2 – 1 – 0 - NA |
| **MY MEDICATIONS** | | | |
| 6. | Tell me about each medication that you are prescribed: name each medication, why you take that medication, and the dose and the time(s) you take your medications daily. |  | 2 – 1 – 0 - NA |
| 7. | Do you think you have any side effects from your medications? If yes, have you talked to your health care provider(s) about this? Please describe the side effects you think you may have. |  | 2 – 1 – 0 - NA |
| 8. | How do you keep track of the medications that are prescribed for you?  *(med list, app, contact my coordinator)* |  | 2 – 1 – 0 - NA |
| 9. | What is the name of the pharmacy where you get your medications?  Do **you** call your pharmacy independently for medication refills? |  | 2 – 1 – 0 - NA |
| **ADHERENCE** | | | |
| 10. | Tell me about some times when it is difficult to remember to take your medications. |  | 2 – 1 – 0 - NA |
| 11. | How often do you miss your medications in a week? in a month? |  | 2 – 1 – 0 - NA |
| 12. | How would your health benefit by taking your medications on time as prescribed? |  | 2 – 1 – 0 - NA |
| 13. | Do you take your medications independently, without any supervision by your parents/guardians?  If no, describe what kind of help you need to take your medications. |  | 2 – 1 – 0 - NA |
| 14. | How do you make sure that you take your medications at the right time?  *(alarms, pill box, parents*/*guardians, other reminders)* |  | 2 – 1 – 0 - NA |
| 15. | How often do you get your labs checked? How often are you supposed to get your labs checked? How do you keep track of when to get your labs done? *(call coordinator, parents/guardians remind, email)* |  | 2 – 1 – 0 - NA |
| **RISKY BEHAVIORS** | | | |
| 16. | Smoking, drinking and/or taking drugs are behaviors that can affect everyone’s health. Are these behaviors of more concern for you because you have had a transplant? Please explain. |  | 2 – 1 – 0 - NA |
| 17. | If you are with a group of teens or young adults and there is some drinking or drug activity going on, what might you do to avoid getting involved? |  | 2 – 1 – 0 - NA |
| **MANAGING MY HEALTH: WHAT I DO TO STAY HEALTHY** | | | |
| 18. | What types of things do you do to stay healthy? *(exercise/sports, eat well, take my meds, etc.)* |  | 2 – 1 – 0 - NA |
| 19. | What foods should you avoid because you had a transplant? Why should you avoid these foods? |  | 2 – 1 – 0 - NA |
| 20. | Increased sun exposure can lead to skin problems in some transplant patients as they get older. What can you do to protect your skin from the sun so this doesn’t happen to you? |  | 2 – 1 – 0 - NA |
| 21. | List the over-the-counter medications you should avoid because you have had a transplant.  Why should you avoid using these medications? |  | 2 – 1 – 0 - NA |
| 22. | Do you have any health conditions in addition to having a transplant? *(diabetes, hypertension, etc.)*  If yes, what are your other health conditions? What additional care needs do you have for this condition? |  | 2 – 1 – 0 - NA |
| 23. | What do you do if you need medical advice? *(Prompts: call health care provider, research on internet, ask peers, ask parents/guardians, etc.)* |  | 2 – 1 – 0 - NA |
| 24. | Do **you** keep track of your health information independently (labs, appointments, medication changes, procedures)? If yes, how do you do this? If no, who keeps track of your information? |  | 2 – 1 – 0 - NA |
| **MANAGING MY HEALTHCARE NEEDS (SELF-ADVOCACY)** | | | |
| 25. | Do **you** contact your health care provider to check your labs, ask about medications, or to make appointments independently without your parents/guardians’ help? If no, who checks on this information? |  | 2 – 1 – 0 - NA |
| 26. | How do you keep track of your medical appointments? *(calendar, app, phone, parents/guardians)* |  | 2 – 1 – 0 - NA |
| 27. | Do you meet independently with your health care provider (without your parents/guardians) for at least part of your appointment? If 18 or older, do you meet independently with your health care provider(s) for your entire appointment? |  | 2 – 1 – 0 - NA |
| 28. | Do you independently discuss your health care with your health care provider(s) during your appointments with or without your parents/guardians being present? |  | 2 – 1 – 0 - NA |
| 29. | Could you answer questions about your medical history if asked to complete a personal health history form? *(i.e., first appointment with a new physician, going to an ER, etc.)* |  | 2 – 1 – 0 - NA |
| 30. | How would you plan ahead for your health care needs if you were traveling away from home or if there was an emergency situation (i.e. earthquake, flooding, hurricane)? |  | 2 – 1 – 0 - NA |
| 31. | How will you get a referral for an adult health care provider when it is time for you to transfer from the pediatric setting to adult care? |  | 2 – 1 – 0 - NA |
| **MY REPRODUCTIVE HEALTH** | | | |
| 32. | **Females:** Will having a transplant affect your ability to get pregnant? If a woman who had a transplant is pregnant, does having a transplant affect the unborn baby’s health? Do any transplant medications affect the unborn baby?  **Males:** Will having a transplant affect your ability to father a child? |  | 2 – 1 – 0 - NA |
| 33. | Because you have had a transplant, what are your options for birth control if/when you become sexually active? |  | 2 – 1 – 0 - NA |
| 34. | What are sexually transmitted infections (STI)? Do you have a greater risk of getting an STI since you have had a transplant? Why? How can you protect yourself from getting an STI? |  | 2 – 1 – 0 - NA |
| **SCHOOL/WORK** | | | |
| 35. | Are you in school? What type of school? (*traditional, vo-tech, college*) |  | 2 – 1 – 0 - NA |
| 36. | If you are still in school, what concerns do you have about things related to school like your grades, your friends, your behavior and/or attendance? |  | 2 – 1 – 0 - NA |
| 37. | Do you have a job? Tell me about your work. *(type, hours, satisfaction with job)* |  | 2 – 1 – 0 - NA |
| 38. | What are your plans for your future? *(school, job/career, marriage, parenting)* |  | 2 – 1 – 0 - NA |
| 39. | Do you think you will have any limits in what you can do in the future because you have had a transplant? Please explain and/or provide an example. |  | 2 – 1 – 0 - NA |
| **MY SUPPORT SYSTEM** | | | |
| 40. | Sometimes older teens feel stressed or overwhelmed with school, work, family and/or their healthcare needs. What do you do to relax or relieve stress if/when you feel like this? When you need someone to talk to or need help with a problem, who do you like to call/contact?  Why is this person(s) helpful? |  | 2 – 1 – 0 - NA |
| 41. | Do you participate in activities in your school or community with your family or friends?  Tell me about some of the things you like to do. |  | 2 – 1 – 0 - NA |
| **HOW I FEEL ABOUT MYSELF** | | | |
| 42. | What concerns do you have about your health because you have had a transplant? |  | 2 – 1 – 0 - NA |
| 43. | What concerns do you have about your future because you have had a transplant? |  | 2 – 1 – 0 - NA |
| **PAYING FOR MY HEALTH CARE** | | | |
| 44. | What is the name of your current health care insurance provider? |  | 2 – 1 – 0 - NA |
| 45. | Do you have a current insurance card? Where do you keep that insurance information (ID number, phone numbers to call for questions)? *(in cell phone, card in wallet)* |  | 2 – 1 – 0 - NA |
| 46. | In regard to health care insurance, what does the term “out-of-pocket expenses” mean? Do you have any out-of-pocket expenses? *(Co-pays/deductibles)* |  | 2 – 1 – 0 - NA |
| 47. | If your medical expenses are covered by your parent/guardian’s insurance, how old will you be when you lose this coverage? How will you get insurance coverage after you are not covered by your parent/guardian’s insurance? |  | 2 – 1 – 0 - NA |