TRANSITIONS CHECKLIST

YOUNG ADULTS WITH NEUROLOGIC DISORDERS

Patient Name: Date of Birth:

Primary Diagnosis:

Transition Complexity: (low, moderate, or high)

TRANSITION POLICY

☐ Practice policy on transition discussed/shared with youth and parent caregiver. Date: __________

TRANSITION READINESS ASSESSMENT

☐ Conducted transition readiness assessment. Date: __________  Date: __________  Date: __________

☐ Included transition goals and prioritized actions in plan of care. Date: __________  Date: __________  Date: __________

MEDICAL SUMMARY AND EMERGENCY PLAN

☐ Updated and shared medical summary and emergency plan. Date: __________  Date: __________  Date: __________

ADULT MODEL OF CARE

☐ Decision-making, privacy, and consent in adult care discussed with youth and parent/caregiver. If needed, discussed plans for supported decision-making. Date: __________

☐ Timing of transfer discussed with youth and parent/caregiver. Date: __________

☐ Adult provider selected; Date: __________ Provider Name & Contact Information:

☐ First appointment completed; Date: __________

TRANSFER OF CARE

☐ Comprehensive transfer package, including the following, sent. Date: __________

☐ Transfer letter, including effective of date of transfer of care to adult provider

☐ Final transition readiness assessment

☐ Plan of care, including goals and actions.

☐ Updated medical summary and emergency care plan.

☐ Legal documents, if needed.

☐ Condition fact sheet, if needed.

☐ Additional provider records, if needed.

☐ Communicated with adult provider about transfer. Date: __________

☐ Elicited feedback from young adult after transfer from pediatric care. Date: __________