SELF-CARE ASSESSMENT (YOUTH/YOUNG ADULTS)

YOUNG ADULTS WITH NEUROLOGIC DISORDERS

Instructions: This document should be completed by youth and young adults (aged 14-25 years old). However, if the youth/young adult is unable to complete this document, his/her parent or caregiver should fill out "Self-Care Assessment (Parents/Caregiver)".

Intent: This document will help us to learn:

1. What you already know about your health
2. What you already know about using health care
3. What areas that you think you want or need to learn more about

If you need help filling out the form, please let us know.

Today's Date:

Patient Name: Date of Birth: Primary Diagnosis:

Caregiver Name: Relationship to Patient: Are you the main caregiver? (yes/no)

LEGAL CHOICES FOR MAKING HEALTH CARE DECISIONS

☐ I can make my own health care choices.

☐ I need some help with making health care choices. Name: Consent:

☐ I have a legal guardian. Name:

☐ I need a referral to community services for legal help with health care decisions and guardianship.

PERSONAL CARE

☐ I care for all my needs.

☐ I care for my own needs with help.

☐ I am unable to provide self-care, but can tell others my needs.

☐ I require total personal care assistance.

SELF-CARE IMPORTANCE

On a scale of 0 to 10, please pick the number that best describes how you feel right now.

How **important** is it for you to take care of your own health care?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0 (not important)	1	2	3	4	5	6	7	8	9	10 (very important)

How **confident** do you feel about your ability to take care of your own health care?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0 (not confident)	1	2	3	4	5	6	7	8	9	10 (very confident)

MY HEALTH

Please check the box that applies to you right now.

	Yes, I know this	I need to still learn this	Someone needs to do this… who?
I know what medical conditions I have	☐	☐	☐
I know what my medications are for	☐	☐	☐
I know what to do if I have a medical emergency.	☐	☐	☐
I take my medicines without someone reminding me.	☐	☐	☐
I know what medicines I should not take.	☐	☐	☐
I know what I am allergic to.	☐	☐	☐
I can name at least 2 people who can help with my health goals.	☐	☐	☐
I can explain to people how my beliefs affect my care choices.	☐	☐	☐

USING HEALTH CARE

Please check the box that applies to you right now.

	Yes, I know this	I need to still learn this	Someone needs to do this… who?
I know or I can find my doctor's phone number.	☐	☐	☐
I can make my own doctor appointments.	☐	☐	☐
Before a visit, I think about questions to ask.	☐	☐	☐
I have a way to get to my doctor's office.	☐	☐	☐
I know I should show up 15 minutes before my visit to check in.	☐	☐	☐
I know where to go or call when my doctor's office is closed.	☐	☐	☐
I can provide my medical information to healthcare staff (including a summary of my medial history and emergency care plan).	☐	☐	☐
I have a copy of my plan of care.	☐	☐	☐
I know how to fill out medical forms.	☐	☐	☐
I know how to ask to be seen by another doctor or therapist.	☐	☐	☐
I know where my pharmacy is and what to do if I run out of my medicines.	☐	☐	☐
I know where to get a blood test or x-rays if the doctor orders them.	☐	☐	☐
I carry my health information with me every day (e.g. insurance card, allergies, medications, and emergency phone numbers).	☐	☐	☐
I have a plan so I can keep my health insurance after 18 or older.	☐	☐	☐

OTHER COMMENTS