

SELF-CARE ASSESSMENT (PARENTS/CAREGIVERS)

YOUNG ADULTS WITH NEUROLOGIC DISORDERS

Instructions: This document should be completed by the parents and/or caregivers of the youth/young adult with a neurologic condition. If possible, the youth/young adult should also complete the "Self-Care Assessment (Youth/Young Adult)" form.

Intent: This document will help us see what your youth/young adult already knows about his/her health; and will help us find areas that you think they (or you) need to know 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)

DECISION-MAKING/GUARDIANSHIP

- My young adult can make his/her own health care choices.
- My young adult needs some help with making health care choices. Name: _____ Consent: _____
- My young adult has a legal guardian. Name: _____
- My young adult/I need a referral to community services for legal help with health care decisions and guardianship.

PERSONAL CARE

- My young adult can care for all his/her needs.
- My young adult can care for his/her own needs with help.
- My young adult is unable to care for himself/herself, but can tell others his/her needs.
- My young adult requires help for all his/her needs.

TRANSITION AND 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 your youth/young adult to take care of his/her own health care?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0 (not important)	1	2	3	4	5	6	7	8	9	10 (very important)

How **confident** do you feel about your youth/young adult's ability to take care of his/her own health care?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0 (not confident)	1	2	3	4	5	6	7	8	9	10 (very confident)

UNDERSTANDING YOUNG ADULT'S HEALTH

Please check the box that applies to you right now.

Check if none of the options below apply (for example, totally dependent care)

	Yes, he/she knows this	He/she needs to still learn this	I need to learn this
My young adult knows his/her medical needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult can tell other people what his/her medical needs are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows what to do if he/she has a medical emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows the medicines he/she takes and what they are for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult can take his/her medicine by themselves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult can take his/her medicine without a reminder.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows what he/she is allergic to, including medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult can name 2-3 people who can help him/her with his/her health goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

USING HEALTH CARE

Please check the box that applies to you right now.

Check if none of the options below apply (for example, totally dependent care)

	Yes, he/she knows this	He/she needs to still learn this	I need to learn this
My young adult knows or can find his/her doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult makes his/her own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, my young adult thinks about questions to ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult has a way to get to his/her doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows he/she should show up 15 minutes before the visit to check in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows where to get care when his/her doctor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult has a folder at home with his/her medical information, including medical summary and emergency care plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult has a copy of his/her plan of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows how to fill out medical forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows how to ask for a form to be seen by other another doctor/therapist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows where his/her pharmacy is and what to do if he/she runs out of medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult knows where to get a blood test or x-rays if the doctor orders them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult carries health information with him/her every day (e.g. insurance card, allergies, medications, and emergency phone numbers).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My young adult has a plan so he/she can keep his/her health insurance after 18 or older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>