

Parent/carer's transition plan

Name of parent: _____

Name of patient: _____

Date: Review (1) Review (2) Review (3) _____

Internet access: YES/NO _____



This transition plan is designed to help parents and carers feel confident about their knowledge and skills during the period of transition. Over the next few years we aim to equip your son/daughter and you with the necessary skills to manage their condition and hopefully increase your confidence and that of your son/daughter to transfer to adult services

Knowledge and skills

	Yes	No	N/A
I understand the meaning of transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know who's in the team and their respective roles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know about resources that offer support for parents/carers of young people with my son/daughter's condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand what is likely to happen in the future regarding my son/daughter's condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the changes (physical and emotional) which occur during adolescence and how their condition potentially affects and is affected by this development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident my son/daughter is knowledgeable about their condition and it's therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I encourage my child to regularly exercise. I am aware of any restrictions my son/daughter may have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in teaching my son/daughter to become responsible for their own medication at home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent/carers transition plan

Encouraging independence

	Yes	No	N/A
Is your son/daughter independent at home - dressing, bathing, preparing meals, doing chores, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident for my son/daughter to be seen on their own in clinic for part or all of clinic visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand my son/daughter's rights to information, privacy and confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to advise my son/daughter about financial help and other support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Healthy lifestyle

I understand the importance of an appropriate healthy diet for young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the effect of smoking, drugs and/or alcohol on my son/daughter's condition and general health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where to access reliable sexual health information for young people and their parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preparation for adult services

I feel confident in teaching my son/daughter how to contact the hospital themselves and to organise their repeat prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the differences between paediatric and adult medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know the plan for my son/daughter's medical care when he/she is an adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other things you have concerns about or would like extra help/advice with:

Thank you for taking the time to complete this plan. Please take time to look at our book shelf in the clinic area which has resources available for young people and parents to take away.