**AST TRANSITION READINESS ASSESSMENT TOOL**



**MIDDLE TRANSITION (14-16 YEARS)**

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

|  | **DOMAINS** | **COMMENTS** | **SCORE** |
| --- | --- | --- | --- |
| **MY TRANSPLANT (Ages 14-16 years)** | | | |
| 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 |
| **MY MEDICATIONS** | | | |
| 5. | What are the names of your medications and the dose of each? Why do you take each of them? What times do you take them? |  | 2 – 1 – 0 - NA |
| 6. | 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 |
| 7. | Do you keep a list of your medications with you? *(in your cell phone, wallet)* |  | 2 – 1 – 0 - NA |
| 8. | What is the name of the pharmacy where you get your medications? Do you have the phone number or do you know how to get the phone number? Who calls when you need refills? |  | 2 – 1 – 0 - NA |
| **ADHERENCE** | | | |
| 9. | Tell me about some times when it’s hard to remember to take your medications. |  | 2 – 1 – 0 - NA |
| 10. | How many times do you think you miss taking your medications in a week? in a month? |  | 2 – 1 – 0 - NA |
| 11. | How would your health benefit by taking your medications on time every day? |  | 2 – 1 – 0 - NA |
| 12. | Are **you** responsible for taking your medications every day **OR**  do **your parents/guardians** remind you and/or give you your medications? |  | 2 – 1 – 0 - NA |
| 13. | What helps you take your medications at the right time every day?  *(alarms, pill box, parents/guardians, other reminders)* |  | 2 – 1 – 0 - NA |
| 14. | How often are you supposed to be getting your labs checked? |  | 2 – 1 – 0 - NA |
| **RISK TAKING BEHAVIORS:** | | | |
| 15. | 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? Why or why not? |  | 2 – 1 – 0 - NA |
| **MANAGING MY HEALTH: WHAT I DO TO STAY HEALTHY** | | | |
| 16. | What types of things do you like to do to stay healthy? *(exercise/play, eat well, take my meds, etc.)* |  | 2 – 1 – 0 - NA |
| 17. | Are there any foods you should not eat because you had a transplant?  If yes, can you name any? Why should you avoid the food(s) you listed? |  | 2 – 1 – 0 - NA |
| 18. | Being out in the sun a lot can lead to skin problems in some transplant patients when 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 |
| 19. | Are there any over-the-counter medications you should avoid because you have a transplant?  If yes, please name the ones you know. Why should you avoid taking this/these medication(s)? |  | 2 – 1 – 0 - NA |
| 20. | Do you have any health conditions in addition to having a transplant? *(diabetes, hypertension, etc.)*  If yes, what are your other health conditions? |  | 2 – 1 – 0 - NA |
| **MANAGING MY HEALTH CARE NEEDS (SELF-ADVOCACY)** | | | |
| 21. | Who calls your health care provider (transplant coordinator) to check your labs, ask about medications, or make appointments? If your parents/guardians call, do you discuss the information (lab results, med changes, etc.) with them? |  | 2 – 1 – 0 - NA |
| 22. | Do **you** keep track of any of your medical appointments on a calendar, phone or other device? |  | 2 – 1 – 0 - NA |
| 23. | Do you usually talk to your health care provider during your appointments without a parent/guardian present for at least part of the time? Optional: *How comfortable do you feel about talking to your health care providers about your health?* |  | 2 – 1 – 0 - NA |
| 24. | If you needed a copy of your medical records (*i.e. job application, school or sports physical*), how would you get the information or whom you would contact for help? |  | 2 – 1 – 0 - NA |
| 25. | What is your plan to have your medications if there was an emergency situation (i.e. earthquake, flooding, hurricane)? |  | 2 – 1 – 0 - NA |
| **MY REPRODUCTIVE HEALTH** | | | |
| 26. | Do you think that having a transplant affects how your body develops during puberty?  Please explain. |  | 2 – 1 – 0 - NA |
| 27. | **Girls:** 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?  **Boys**: Will having a transplant affect your ability to father a child? |  | 2 – 1 – 0 - NA |
| 28. | Because you have had a transplant, what are your options for birth control if/when you become sexually active? |  | 2 – 1 – 0 - NA |
| 29. | What are sexually transmitted infections (STI)? Do you have a greater risk of getting an STI because you have had a transplant? Why? How can you protect yourself from getting an STI? |  | 2 – 1 – 0 - NA |
| **GOING TO SCHOOL** | | | |
| 30. | How is school going? Prompts: Tell me about your grades, your friends, your behavior in school, etc. Are there any things you worry about related to school? Please explain. |  | 2 – 1 – 0 - NA |
| 31. | How many days of school do you miss in a week? in a month? |  | 2 – 1 – 0 - NA |
| 32. | What are you thinking about doing after you complete high school? |  | 2 – 1 – 0 - NA |
| 33. | Do you think you will have any limits to what you can do in the future because you had a transplant? If yes, please give me an example. |  | 2 – 1 – 0 - NA |
| **MY SUPPORT SYSTEM** | | | |
| 34. | Sometimes teens your age feel stressed or overwhelmed with school, family and/or their healthcare needs. What do you do to relax or relieve stress if/when you feel like this? Whom do you like to call/contact when you need someone to talk to or need help? Why is this person(s) helpful? |  | 2 – 1 – 0 - NA |
| 35. | 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** | | | |
| 36. | Do you ever worry about your health (how you are doing) because you have had a transplant? Please give me an example. |  | 2 – 1 – 0 - NA |
| **PAYING FOR MY HEALTH CARE** | | | |
| 37. | How do people pay for their medications and medical care? |  | 2 – 1 – 0 - NA |
| 38. | What is the name of your health insurance provider? |  | 2 – 1 – 0 - NA |
| 39. | Will your insurance change when you get older? Do you know when this might happen? |  | 2 – 1 – 0 - NA |
| 40. | What is a copay? Do you know if you have to pay copays on any of your medications? |  | 2 – 1 – 0 - NA |