Diabetes Transition Independence Resource

Consider the following statements. Yours answers will be discussed with your Transition Nurse.

Name: **Date:**

Differences between Starship and Adult Services

	YES	MAYBE	NO
I speak up for myself and can tell health professionals what I need.	○	○	○
I know the type of doctors I will need to see as an adult with diabetes.	○	○	○
I have a GP I like and I will continue to see as an adult	○	○	○
I understand what "screening for diabetes complications" means.	○	○	○
I understand that prescriptions need to be taken to a pharmacy	○	○	○
I know I ***may*** need to obtain scripts via my GP in adults	○	○	○
I know my HbA1c ***may*** need to be undertaken at a lab in adults.	○	○	○
I know that phone support in adults is provided during 9-5pm	○	○	○
I know clinic appointments can vary between 3monthly to annually	○	○	○
I know where my adult diabetes service is located	○	○	○

My Diabetes

I can describe my diabetes management to others	○	○	○
I can describe long term health risks related to my diabetes	○	○	○
I can describe recommended screening requirements	○	○	○
I know what to do if I get sick	○	○	○
I take responsibility for my health records	○	○	○
I take responsibility for taking my prescribed treatment	○	○	○
I am happy with my current treatment regime	○	○	○

My Youth Health

I understand what confidentiality and privacy means	○	○	○
I know how to avoid risks to myself: like STD's or pregnancy	○	○	○
I hang out with friends who believe in me and are good to me	○	○	○
I can explain the risks if I use alcohol, drugs or cigarettes	○	○	○
I can explain the precautions around driving and diabetes	○	○	○
I often feel sad or "blue"	○	○	○
I worry about my future	○	○	○
I would like to talk about other issues in clinic today	○	○	○

Starship Diabetes Transition Pack 2016.
Adapted from The Endocrine Society "Self-assessment of worries, concerns, and burdens related to diabetes and preparation for transitioning tool". 2015. http://www.endocrinetransitions.org/type-1-diabetes/

SELF-HELD TRANSITION PLAN (To be completed by young person**)**	
NAME:	NHI:
CONTACT NUMBER:	CONTACT EMAIL
HEALTH CONCERNS:	ALLERGIES:

Screening Status					
Retinopathy	Persistent Microalbuminuria	Lipids	Thyroid Function	Coeliac Disease	Antibody Status
YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Minimal Mild Moderate Severe Unknown	ACEI therapy ARB therapy No treatment Unknown	Normal Abnormal Unknown	Normal Abnormal Unknown	Gluten Free Not Treated Unknown	Positive GAD Positive IA2 Positive GAD & IA2 Unknown

Starship Transition Nurse	Planned date of referral to adult service	Planned receiving adult service	Adult service transition link person	Transfer status	
				In Process	Complete (captured into young adult services)
		ADHB WDHB NORTH WDHB WEST CMDHB OTHER-			

General Practitioner			
Name:	Practice Name	Address:	Telephone:

YOUNG PERSON'S OBJECTIVES/AIMS/WORRIES DURING TRANSITION

1.

2.

3.

4.

Adapted for use within NZ with permission from the Royal Children's Hospital (RCH) Transition Support Service "Transfer to adult services passport". January 2017.

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Transition Satisfaction Survey

The information you provide will assist us in developing plans for improvement and in making any changes to existing transition services.

For the Young Person to Complete

Has your experience in the Transition Clinic (14-16yrs) been positive? **YES / NO (**please circle)

Do you feel anxious about transferring to adult services? **YES / NO** (please circle)

If Yes, is there anything we can do to help you feel less anxious (please explain)

Has seeing the nurse at clinic helped prepare you for transition? **YES / NO** (please circle)

Is there anything you would change about the Transition Clinic? **YES / NO (**please circle)

If you would change something what would it be?

Are you happy for Starship to contact you in 6months to see how your transition to adult services went? **YES / NO (**please circle)

Your Email: _____ *Your cellphone*: _____

Are you happy for Starship diabetes team to track your attendance at adult clinics and your health care outcomes until you are 25 years old? **YES / NO (**please circle)

For the Parent / Carer to complete

Has your experience in the Transition Clinic (14-16yrs) been positive? **YES / NO (**please circle)

Has seeing the nurse in clinic helped prepare your child for transition? **YES / NO (**please circle)

Is there anything you would change about the Transition Clinic? **YES / NO (**please circle)

If you would change something about transition clinic what would it be?

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