** AST TRANSITION READINESS ASSESSMENT TOOL**

**EARLY TRANSITION (11-13 YEARS)**

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

|  | **DOMAINS** | **COMMENTS** | **SCORE** |
| --- | --- | --- | --- |
| **MY TRANSPLANT**  |
| 1. | Why did you need a (liver, kidney, heart, lung, intestine) transplant? |  | 2 – 1 – 0 - NA |
| 2. | What is rejection? *Prompts: If your health care provider thinks that you are having rejection, what would he/she look for? If you had rejection, what would happen?*  |  | 2 – 1 – 0 - NA |
| 3. | Why do you need to get your labs checked routinely (every month, every 3 months, etc.)? |  | 2 – 1 – 0 - NA |
| **MY MEDICATIONS** |
| 4. | Tell me the names of your medications and why you take each of them. |  | 2 – 1 – 0 - NA |
| 5. | What times do you take these medications every day? |  | 2 – 1 – 0 - NA |
| 6. | Do your **parents/guardians** keep a list of your medications? Do **you** have a list of your medications? If yes, where do you keep that list? |  | 2 – 1 – 0 - NA |
| **ADHERENCE** |
| 7. | Tell me about some times when it’s hard to remember to take your medications. |  | 2 – 1 – 0 - NA |
| 8. | How many times do you think you miss taking your medications in a week? in a month? |  | 2 – 1 – 0 - NA |
| 9. | Why should you take your medications every day and on time? |  | 2 – 1 – 0 - NA |
| 10. | Do your parents/guardians remind you that it is time to take your medications **OR** do you remember to take your medications and let them know you are taking them? |  | 2 – 1 – 0 - NA |
| 11. | Do your parents/guardians give you your medicines when it is time to take them **OR**do you take them on your own? |  | 2 – 1 – 0 - NA |
| **RISK-TAKING BEHAVIORS** *For >****12 year olds*** *only or as appropriate based on psychosocial development and cultural context.* |
| 12. | Smoking, drinking alcohol or taking drugs are behaviors that affect everyone’s health.Do you think these behaviors (smoking, drinking alcohol or taking drugs) are more harmful for someone who has had a transplant? Why? |  | 2 – 1 – 0 - NA |
| **MANAGING MY HEALTH: WHAT I DO TO STAY HEALTHY** |
| 13. | What types of things do you like to do to stay healthy? *(exercise/play, eat well, take my meds, get labs etc.)* |  | 2 – 1 – 0 - NA |
| 14. | Are there any foods you should not eat because you had a transplant? If yes, can you name any? |  | 2 – 1 – 0 - NA |
| 15. | 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 |
| **MANAGING MY HEALTH CARE NEEDS (SELF-ADVOCACY)** |
| 16. | Do you and your parents/guardians talk about your health and how you are doing with your transplant? Give me an example of how you discuss your health information. |  | 2 – 1 – 0 - NA |
| 17. | Who keeps track of how much medicine you have so you don’t run out?  |  | 2 – 1 – 0 - NA |
| 18. | Do you talk to your health care provider for at least a few minutes about how you feel when you have a check-up? Do you feel comfortable talking to him/her about your health? |  | 2 – 1 – 0 - NA |
| 19. | Do you and your parents/guardians have a plan to be sure to have medications in case of an emergency like an earthquake, hurricane or flooding? Describe what you will do if this would happen. |  | 2 – 1 – 0 - NA |
| **MY REPRODUCTIVE HEALTH** *For >****12 year olds*** *only or as appropriate based on psychosocial development and cultural context.* |
| 20. | Do you think that having a transplant could affect how your body develops during your teen years (puberty)?  |  | 2 – 1 – 0 - NA |
| 21. | **Girls:** Will having a transplant affect your ability to have a baby when you are older?  Do you think having a transplant might affect the unborn baby’s health? **Boys:** Will having a transplant affect your ability to father a child when you are an adult?  |  | 2 – 1 – 0 - NA |
| 22. | What are sexually transmitted infections (STI)? Do you think you have a greater chance of getting an STI because you had a transplant? Why? |  | 2 – 1 – 0 - NA |
| **GOING TO SCHOOL/MY FUTURE** |
| 23. | 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 |
| 24. | How many days of school do you miss in a week? in a month? |  | 2 – 1 – 0 - NA |
| 25. | What do you think you might want to do when you get older? *(prompts: work/career, college, being a parent)* |  | 2 – 1 – 0 - NA |
| 26. | Do you think there are things you might not be able to do when you are older because you had a transplant? What do you think you might be limited in doing?  |  | 2 – 1 – 0 - NA |
| **MY SUPPORT SYSTEM** |
| 27. | 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 |
| 28. | What activities do you like to participate in with your family or friends within your school and community? Tell me about some things you do.  |  | 2 – 1 – 0 - NA |
| **HOW I FEEL ABOUT MYSELF** |
| 29. | Do you ever worry about your health (how you are doing) because you have had a transplant? |  | 2 – 1 – 0 - NA |
| **PAYING FOR MY HEALTH CARE** |
| 30. | How do people pay for their medications and their health care needs? *(being in the hospital, surgeries, tests, labs)* |  | 2 – 1 – 0 - NA |