**PARENT/GUARDIAN ACTION FORM**

**LATE TRANSITION (17 years and older)**

**MY CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **DOMAINS/GOALS** | **STRATEGIES to ACHIEVE GOALS** | **COMPLETED** |
| --- | --- | --- |
| **TRANSPLANT KNOWLEDGE** | | |
| * My child can state why he had a transplant. * My child has an understanding of rejection and how it is diagnosed and treated. * My child knows why it is important to get his labs routinely. * My child has a personal health care summary (hard copy or electronic) |  |  |
| **MEDICATIONS** | | |
| * My child can correctly state the names of all his medications, the reason he takes them, the dose and the times he takes them. * My child can describe any side effects he may have from his medications and can discuss these with his healthcare provider. * My child has a specific method for keeping track of his medications. * My child knows the name of his pharmacy and contacts the pharmacy independently to refill his prescriptions before he runs out of medication. |  |  |
| **ADHERENCE** | | |
| * My child independently takes his medications every day and on time. * My child knows how often he is supposed to get his labs. |  |  |
| **RISK-TAKING BEHAVIORS** | | |
| * My child knows that risk-taking behaviors (smoking, drinking, taking street drugs) are of more concern for him because he had a transplant.   + My child and I continue to discuss how risk-taking behaviors can be harmful to his health and the health of the transplanted organ.   + My child can contact his healthcare providers for questions about this or additional information. |  |  |
| **MANAGING MY HEALTH: WHAT I DO TO STAY HEALTHY** | | |
| * My child knows how to maintain a healthy life style through good nutrition, activities/exercise, and adherence to health care needs.   + My child knows which foods to avoid because he has had a transplant and why they should be avoided.   + My child knows how to protect his skin from the sun, uses sun protection when appropriate, and knows why this is important.   + My child knows which over-the-counter medications he should not take and why they should be avoided.   + My child can contact his healthcare providers for more information on these topics and can discuss his questions during appointments.   + My child can discuss other health care conditions that he has. |  |  |
| **MANAGING MY HEALTH CARE NEEDS: SELF-ADVOCACY** | | |
| * My child is independently managing his healthcare needs by:   + independently discussing his care with healthcare providers.   + keeping track of his appointments, medications and labs.   + completing a health history when requested.   + planning for his healthcare and medications in case of an emergency or extended travel.   + having an understanding of how to get a referral for adult healthcare providers or knowing whom to ask for help to do this. |  |  |
| **REPRODUCTIVE HEALTH** | | |
| * My child can state how having a transplant may affect him/her in regard to conceiving/fathering a child. * My child understands his/her increased risk for sexually transmitted infections and knows how to prevent STIs if/when sexually active. * My child knows what type of birth control is best if or when he/she is sexually active.   + I am available to discuss my child’s questions about reproductive health issues as needed.   + I encourage my child to ask questions and get more information from his/her healthcare providers. |  |  |
| **GOING TO SCHOOL/MY FUTURE** | | |
| * My child is actively thinking and planning about his/her future.   + I continue to encourage and support my child’s interests in plans for school and employment.   + My child can contact his healthcare provider to discuss any concerns he may have in choosing a career/job because he has a transplant. |  |  |
| **MY SUPPORT SYSTEM** | | |
| * My child has identified family, peers, and healthcare providers he will contact for support if he is stressed or overwhelmed with school, family or his health care. * My child is involved in family, community and/or school activities. * If my child is having problems with stress, anxiety or depression he knows he can call a healthcare provider for advice. |  |  |
| **HOW I FEEL ABOUT MYSELF** | | |
| * My child feels good about himself as an older teen and in having a transplant.   + When needed, my child discusses his feelings or healthcare issues with other supportive people (family, friends, teachers, healthcare providers).   + I am available to my child as needed for support and to let me know how he is doing at school/work and with friends. |  |  |
| **PAYING FOR MY HEALTHCARE** | | |
| * My child can the name his health insurance provider and knows that his insurance will change as he gets older or with employment. * My child can state what a co-pay is and knows what the co-pay costs are for his medications. * My child can access his insurance information (ID number, phone number) when needed. |  |  |