



Preparing for My Adult Health Care



Name: _____ Birthdate: _____ Age: _____

- Completed by Youth/Young Adult
- Completed by Parent/Caregiver, if youth/young adult is unable to do so
 - * Point of view: Parent or Child (circle)

Instruction: For each statement below, check the best answer. Date: _____

MY HEALTH	Yes	I am learning	I want help to learn	Does not apply
I live healthy (brushing/flossing teeth, healthy foods, exercise, sleep)				
I know the name of my health conditions and how they affect me				
I know how to get help when I'm not feeling well				

MY DOCTORS and PROVIDERS	Yes	I am learning	I want help to learn	Does not apply
I can schedule visits with my doctor and dentist regularly for check-ups				
I talk with my doctor/provider about my concerns				
I know my doctor's names and contact information				
I plan my rides to my appointments				

MY MEDICATIONS	Yes	I am learning	I want help to learn	Does not apply
I know my medicines (what they are, how much to take, and when to take them)				
I know how to get more refills of my medicines				
I know the name and location of my pharmacy				
*Name of pharmacy: _____				

MY MEDICAL SUPPLIES	Yes	I am learning	I want help to learn	Does not apply
I know how to order my supplies, formula, batteries, etc.				
I know who to call when my equipment does not work, or when it needs to be replaced				
I know how to file my records and receipts				

MY HEALTH INSURANCE	Yes	I am learning	I want help to learn	Does not apply
I carry my insurance card in my wallet				
I understand my medical insurance and how to use it				
I know how to get insurance when I turn 18-years-old, 19-years-old and 26-years-old				

MY ADULT HEALTH CARE	Yes	I am learning	I want help to learn	Does not apply
At 18-years-old, I know I have the right to see the doctor alone or choose to have my support people with me				
I help in making medical decisions				
I keep my own health record up-to-date				
I know who my adult health providers will be				

Things I have already worked on:

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Things to Work on this year:

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Signature: _____

(person filling out this form)

CSHNB Worker: _____