

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

The activities listed will help youth gain the skills and abilities needed to reach their highest level of independence and ability. Some of these activities may not apply to everyone.

<b>HEALTH CARE Skills and Abilities:</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Need More Info</b>
1. Can you describe your own health condition/disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can you describe how your health condition/disability affects your daily life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you wear or carry a medical alert (list of allergies, medical conditions, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you tell the doctor or nurse how you feel and what you think you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you answer questions that are asked by the doctor or nurse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you ask questions of the doctor or nurse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you call the doctor about unusual changes in your health (allergic reaction)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you take part in making health care decisions with your parents and doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you see your doctor without your family/parents in the room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you call the doctor's office to make an appointment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you make a list of questions before the doctor's visit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you sign consent forms for your medical treatment (surgery, tests, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you fill out the medical history form and list your allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have a guardian or power of attorney for health care, if needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you know when to call 9-1-1 or seek urgent medical care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you know your rights to control how your health information is used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you keep a calendar or list of your appointments on your own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you follow up on any referral for tests, checkups or labs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you arrange for your ride to medical appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you found an adult doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you made your first appointment with an adult doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MEDICATIONS/TREATMENTS Skills and Abilities:</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Need More Info</b>
22. Do you take part in your medical treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you know the names of your medicines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Do you know why you take each of your medicines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you know the side effects or bad reactions of each medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For more detailed information on specific skills and abilities, use the *Transition Skills Tips and Tools* sheets found at: <http://internet.dsc.c.uic.edu/dscroot/parents/transition.asp>



<b>MEDICATIONS/TREATMENTS Skills and Abilities: (continued)</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Need More Info</b>
26. Do you take your own medicines, with reminder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Do you direct (know the steps and tell another how to do it) your treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Are you able to do your own treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you know what can happen if you skip your treatments or medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Do you take your medicines correctly and on your own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Do you use and take care of medical equipment and supplies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Do you call the company when there is a problem with your equipment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Do you reorder medicines and/or supplies before they run out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Do you fill a prescription if you need to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INSURANCE Skills and Abilities:</b>	<b>YES</b>	<b>NO</b>	<b>N/A</b>	<b>Need More Info</b>
35. Do you understand what health insurance is for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Do you carry a health insurance card?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Do you show your health insurance card at your medical appointments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Do you know what your health insurance covers - co-pays, deductibles, referrals, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Do you apply for health insurance when you lose your current coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**TIPS FOR USING THIS SKILLS LIST:**

Think about the skills you want to work on. Make notes of your needs and concerns. Then you can talk about the next steps to take with the people that are helping you prepare for your future.

**Notes to Myself:** For each “Need More Info” item you checked, list questions you have or what you would like to know more about.

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**Next Steps – Goals:** List what you need to work on to help you learn how to take care of yourself in the future. You can ask the people who are helping you plan for your future to work on this with you.

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I would like more information about:  Insurance     Medicaid     Managing My Own Health Care  
 Other \_\_\_\_\_

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