



Adapted from the Got Transition Initiative

Please fill out this form to help us see what you already know about your health, using health care and areas that you need to learn more about. If you need help completing this form, please let us know.

Today's Date (mm/dd/yyyy):										
Name (Last/First):						Date of Birth (mm/dd/yyyy):				
Transition and Self-Care Importance and Confidence										
<i>On a scale of 0 to 10, please circle the number that best describes how you feel right now</i>										
Please rate how confident you feel about taking charge of your heart health care										
0 (Not)	1	2	3	4	5	6	7	8	9	10 (Very)
Please rate how confident you feel moving to adult-focused heart care										
0 (Not)	1	2	3	4	5	6	7	8	9	10 (Very)

My Health			
<i>Please check the box that applies to you right now</i>	<i>Yes, I know this</i>	<i>I need to learn more</i>	<i>Not applicable</i>
I can name and/or describe my heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can name and/or describe the cardiac surgeries or procedures I have had	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know the names and doses of my medications and when to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know my allergies to medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know or can find the name and contact information for my heart doctor (cardiologist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know I need life-long heart care from a congenital heart disease specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know I need to maintain health insurance throughout my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Using Health Care <i>Please check the box that applies to you right now.</i>	<i>Yes, I know this</i>	<i>I need to learn more</i>	<i>Not applicable</i>
I feel comfortable asking my doctor or nurse questions about my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I answer my doctor's or nurse's questions on my own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, I think about questions to ask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know to ask my doctor or nurse for recommendations if I need to see other doctors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take part in making choices about my health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to refill my medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what to do in case I have a medical emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to contact my health insurance company with questions or concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a paper or electronic file for my medical information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand how health care privacy changes for adults (age 18)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry important health information with me every day (e.g. insurance card, allergies, medications, emergency contact information, medical summary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>