AMERICAN COLLEGE of CARDIOLOGY

Pediatric to Adult Care Transition Tools

Congenital Heart Transition Self-Assessment for Pediatric Patients — Six Core Elements of Health Care Transition 2.0

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 ***On a scale of 0 to 10, please circle the number that best describes how you feel right now***										
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 ***Please check the box that applies to you right now***	*Yes, I know this*	*I need to learn more*	*Not applicable*
I can name and/or describe my heart condition	☐	☐	☐
I can name and/or describe the cardiac surgeries or procedures I have had	☐	☐	☐
I know the names and doses of my medications and when to take them	☐	☐	☐
I know my allergies to medications	☐	☐	☐
I know or can find the name and contact information for my heart doctor (cardiologist)	☐	☐	☐
I know I need life-long heart care from a congenital heart disease specialist	☐	☐	☐
I know I need to maintain health insurance throughout my life	☐	☐	☐

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