**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_ Today’s Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_ (MRN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

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| --- |
| **Transition Readiness Assessment Questionnaire (TRAQ)** |

***Directions to Youth and Young Adults:*** Please check the box that best describes ***your*** skill level in the following areas that are important for transition to adult health care. There is no right or wrong answer and your answers will remain confidential and private.

***Directions to Caregivers/Parents:*** If your youth or young adult is unable to complete the tasks below on their own, please check the box that best describes ***your*** skill level. **Check here** if you are a parent/caregiver completing this form­­­­.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **No,**  **I do not know how** | **No,**  **but I want to learn** | **No,**  **but I am learning to do this** | **Yes,**  **I have started doing this** | **Yes,**  **I always do this when I need to** |
| ***Managing Medications*** |  |  |  |  |  |
| 1. Do you fill a prescription if you need to? |  |  |  |  |  |
| 1. Do you know what to do if you are having a bad reaction to your medications? |  |  |  |  |  |
| 1. Do you take medications correctly and on your own? |  |  |  |  |  |
| 1. Do you reorder medications before they run out? |  |  |  |  |  |
| ***Appointment Keeping*** |  |  |  |  |  |
| 1. Do you call the doctor’s office to make an appointment? |  |  |  |  |  |
| 1. Do you follow-up on any referral for tests, check-ups or labs? |  |  |  |  |  |
| 1. Do you arrange for your ride to medical appointments? |  |  |  |  |  |
| 1. Do you call the doctor about unusual changes in your health (For example: Allergic reactions)? |  |  |  |  |  |
| 1. Do you apply for health insurance if you lose your current coverage? |  |  |  |  |  |
| 1. Do you know what your health insurance covers? |  |  |  |  |  |
| 1. Do you manage your money & budget household expenses (For example: use checking/debit card)? |  |  |  |  |  |
| ***Tracking Health Issues*** |  |  |  |  |  |
| 1. Do you fill out the medical history form, including a list of your allergies? |  |  |  |  |  |
| 1. Do you keep a calendar or list of medical and other appointments? |  |  |  |  |  |
| 1. Do you make a list of questions before the doctor’s visit? |  |  |  |  |  |
| 1. Do you get financial help with school or work? |  |  |  |  |  |
| ***Talking with Providers*** |  |  |  |  |  |
| 1. Do you tell the doctor or nurse what you are feeling? |  |  |  |  |  |
| 1. Do you answer questions that are asked by the doctor, nurse, or clinic staff? |  |  |  |  |  |
| ***Managing Daily Activities*** |  |  |  |  |  |
| 1. Do you help plan or prepare meals/food? |  |  |  |  |  |
| 1. Do you keep home/room clean or clean-up after meals? |  |  |  |  |  |
| 1. Do you use neighborhood stores and services (For example: Grocery stores and pharmacy stores)? |  |  |  |  |  |