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

|  |
| --- |
| **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)?
 |  |  |  |  |  |