TRANSITION CHECKLIST: Ages 1-5

Patient name: _____ Date of birth: _____

Name of person completing form: _____ Date: _____

Relationship to patient (circle one): Parent(s) CF clinic staff

Please use the following to rate the **FREQUENCY** of each item. (Parents, please use this tool as it applies to your **observations** of your child)

CF HEALTH KNOWLEDGE:	**1 Strongly Disagree**	**2 Disagree**	**3 Agree**	**4 Strongly Agree**	**n/a**
I know that I have cystic fibrosis.	1	2	3	4	n/a
I know that having CF means I have to take medicines and do therapies that my friends don't have to do.	1	2	3	4	n/a
I know that CF means I have to go to the doctor more often than my friends.	1	2	3	4	n/a
I understand that CF is not contagious – I didn't catch it from anyone and no one can catch it from me.	1	2	3	4	n/a
I understand that I've had CF since I was born; I didn't do anything wrong to make this happen to me.	1	2	3	4	n/a

INDEPENDENT HEALTHCARE ACTIONS:	**1 Never**	**2 Sometimes**	**3 Often**	**4 Always**	**n/a**
I tell my parents when I don't feel well or when something hurts.	1	2	3	4	n/a

RELATED HEALTH KNOWLEDGE:	**1 Strongly Disagree**	**2 Disagree**	**3 Agree**	**4 Strongly Agree**	**n/a**
I understand that breathing therapies and treatments help keep my lungs healthy.	1	2	3	4	n/a
I know that taking enzymes helps my body digest food.	1	2	3	4	n/a

INFECTION CONTROL:	**1 Strongly Disagree**	**2 Disagree**	**3 Agree**	**4 Strongly Agree**	**n/a**
I know that my child should avoid direct contact with other individuals with CF whenever possible.	1	2	3	4	n/a
Our family knows how to do good hand hygiene to maintain good infection control, especially during illness.	1	2	3	4	n/a

THERAPIES:	**1**	**2**	**3**	**4**	

	Strongly Disagree	Disagree	Agree	Strongly Agree	n/a
I know how to properly use and set up my child's breathing equipment.	1	2	3	4	n/a
I know how to clean and disinfect my child's breathing equipment (VEST, spacers, neb kits, etc.).	1	2	3	4	n/a
I know how often I need to clean and disinfect my child's breathing equipment.	1	2	3	4	n/a

LIFESTYLE ISSUES:	**1** Strongly Disagree	**2** Disagree	**3** Agree	**4** Strongly Agree	n/a
I understand the importance of eating enough food so that I can stay healthy and strong.	1	2	3	4	n/a

PSYCHOSOCIAL WELL-BEING:	**1** Strongly Disagree	**2** Disagree	**3** Agree	**4** Strongly Agree	n/a
I have friends and play with them regularly.	1	2	3	4	n/a
I know when I feel scared or angry.	1	2	3	4	n/a
I tell my parents when I feel scared or angry.	1	2	3	4	n/a
I am generally happy.	1	2	3	4	n/a

Name: _____ Date of birth: _____

What are your **top 3 concerns** about any area of your (your child's) life? :
1. _____
2. _____
3. _____

How would you like to handle these concerns? : _____
_____

What are your strengths? : _____
_____

What would you like to do better? : _____
_____

Information You Would Like to Have:

- ❑ Medical information
- ❑ Financial assistance resources
- ❑ Insurance
- ❑ Disclosing CF
- ❑ Disability rights
- ❑ Employment
- ❑ Education
- ❑ Financial aid for college
- ❑ Lung Transplantation
- ❑ Advanced Directives
- ❑ Fertility
- ❑ Genetic counseling/ testing
- ❑ CF websites
- ❑ Sexuality
- ❑ Adult CF Clinic
- ❑ Nutrition
- ❑ Infection prevention
- ❑ Vocational counseling
- ❑ Other

For the above, please describe specifics: _____
_____
_____
_____
_____

PLAN: _____
_____
_____
_____
_____

This Checklist completed: ____/____/____
Next Checklist to be completed: ____/____/____

Patient or Guardian Signature: _____

Social Worker Signature: _____