**TRANSITION CHECKLIST: Ages 6-11**

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 some of the symptoms that CF causes for me. | 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 or teacher when I don't feel well or when something hurts. | 1 | 2 | 3 | 4 | n/a |
| I am starting to answer at least one question from my healthcare provider on my own. | 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 |
| I know that it is important to exercise and be active. | 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 Strongly Disagree** | **2 Disagree** | **3 Agree** | **4 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 meals and snacks every day. | 1 | 2 | 3 | 4 | n/a |
| I know the importance of drinking enough water. | 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 or see 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 or a teacher 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: _____