Transition care plan

# For young people with intellectual disability moving to adult health services

Complete the relevant sections of this plan with the young person and their family/carers and use it to guide actions throughout the transition preparation period. This plan is not intended to be used as a referral form.

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| **Last name** | | **First name** | |
| **Date of birth** | **Gender assigned at birth** | | **Pronouns** |
| **Address** | | | |
| **Medical Record Number (MRN)** | | **Height** | **Weight** |
| **Medicare number** | | **Expiry date** | |
| **Aboriginal and/or Torres Strait Islander status** | | | |
| **Language spoken** | | **Interpreter required** (yes/no) | |
| **NDIS** (yes/no/applied) | **Guardianship** (yes/no/applied) | **Immunisation status** | |

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| **Key contact information** | | | |
|  | **Name** | **Email** | **Phone** |
| **Young person** |  |  |  |
| **Parent/carer** |  |  |  |
| **Key transition contact** |  |  |  |
| **NDIS coordinator** **(if applicable)** |  |  |  |
| **Guardian** **(if applicable)** |  |  |  |

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| **Diagnoses and medical conditions** | |
| **1.** |  |
| **2.** |  |
| **3.** |  |

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| **Current treatments and care plans** | |
| **1.** |  |
| **2.** |  |
| **3.** |  |

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| --- | --- | --- | --- |
| **Current medicines** | | | |
| **Medicine name** | **Dosage** | **Frequency** | **Reason** |
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| **Allergies and alerts** | |
| **1.** |  |
| **2.** |  |
| **3.** |  |

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| **Equipment used (including communication tools)** | |
| **1.** |  |
| **2.** |  |
| **3.** |  |

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| **Transition goals** | | | |
| **Young person** | 1. | 2. | 3. |
| **Parent/carer** | 1. | 2. | 3. |
| **Clinician/healthcare team** | 1. | 2. | 3. |

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| **Transition details** | | | | | | |
| **Paediatric healthcare service** | | | **Adult healthcare service** | | | **Transfer date** |
| **Role** | **Name** | **Contact** | **Role** | **Name** | **Contact** |
|  |  |  |  |  |  |  |

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| **General practitioner (GP)** | | | | |
| **Name** | **Clinic** | **Address** | **Phone** | **Email** |
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| **Notes** |
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| **Transition care plan information** | | | | | |
| **Written by** |  | **Date initiated** |  | **Date last revised** |  |