Checklist: transitioning young people with intellectual disability to adult health services

There are several things that health professionals can do to support the transition of young people with intellectual disability to adult health services.

Before transition

- ☐ let the adult health services know that the young person will be transitioning to their care, including timelines
- ☐ discuss any worries the young person may have about moving to adult health services
- ☐ provide the young person with emergency contact numbers
- ☐ identify a key health professional to help the young person throughout the transition process. This may be a GP, nurse navigator, peer worker, or relevant allied health professional
- ☐ provide the young person with a care plan for the transition period
- ☐ tell the young person and their family/carer which new health service/s they are being referred to
- ☐ discuss what the young person can expect in the new health service, including how to make appointments and how to get there
- ☐ confirm whether the young person has their own Medicare card, and tell them how to apply if they do not have one
- ☐ if relevant, inform the young person and their family/carer how to apply to access the NDIS
- ☐ set a start date for formal transition – make the first appointment with the new health service.

During transition

- ☐ introduce the young person to the relevant people in the new health service
- ☐ provide the new health service with all information relevant to the young person's medical history and ongoing care
- ☐ ask the new health service to contact the young person so they can become familiar with each other
- ☐ make sure your communication with the new care team is transparent and timely – be available to answer any questions they may have
- ☐ discuss with the young person and the new health service where the young person should go for any acute health problems (including hospitalisations) during the transition period
- ☐ set a transition completion date with the young person and the new health service, after which any hospitalisation should be to adult hospital services.

After transition

- ☐ contact the young person within three months of the transition completion date to check if all the new health services are in place
- ☐ if there are any service gaps, contact the new health service to facilitate service delivery to the young person and their family/carer.