Transitioning To Adulthood

Children's Hospital
London Health Sciences Centre

Welcome to the Transitional Care Program at Children's Hospital, London Health Sciences Centre (LHSC)

Moving into adulthood can be both exciting and challenging as families try and navigate multiple systems. The goal of the Transitional Planning Clinic at Children's Hospital, LHSC is to provide assistance within the transition planning process that is proactive and results in a detailed, individualized transition plan ensuring that your journey to adult services is a successful transition.

The intent of this guide is to assist you and your family in exploring key areas of transition to adulthood, including: Health care and medical management; education; living arrangements; finances; vocation; and estate planning. If your teen is unable to complete the questions contained in this guide on their own, we encourage you to answer the questions to the best of your ability based on your teen's wishes, interests, and needs.

Section 1: Introduction to Transitional Planning

What is a transition?

Throughout life you have likely heard the word transition. There are many transitions that one can experience. These transitions can include going from hospital to home; transitioning into daycare or school; and then again transitioning into high school.

In healthcare, as you become a teen we start to look at how we will assist you in transitioning from pediatric to adult services. Depending on your healthcare needs, the earlier you start thinking about transitioning the more time you have to ensure that each of your needs will be met once you transition to adult service.

Remember, transition is a process which requires planning and preparation.

When should transition planning to adulthood begin?

Our goal is to ensure transition to adult services occurs as smoothly as possible. Ideally the process will begin as early as 14 years of age so that by the time you reach 18 you can feel confident in the plans you and your family have developed.

How do I know if I require transition planning assistance?

There are numerous ways in which you or your family may be recognized as needing assistance with the transition process. A member of your healthcare team may identify that it is time to start talking about and planning for the transition process. You or one of your family

members may also decide that you would benefit from additional support in planning for your transition.

Section 2: Getting Started

An appointment may be arranged for you and your caregiver(s) for the Transition Planning Clinic in the Smile Zone B2 -202 at Children's Hospital, London Health Sciences Centre (LHSC). During this initial visit, you will meet with the Transitional Care Specialist and a Pediatric Social Worker.

Please take some time to go through this guide and fill out the requested information. Bring the completed Transitional Care Assessment questionnaires and other medical or care related information that you think would be helpful in order for our team to get to know you and your family. This information will further guide our discussion with you during your first & subsequent visits to the Transition Planning Clinic.

Step 1 – Building Your Transition Planning Team

During your visit in the Transition Planning Clinic we will discuss who you may want to be included as part of your Transition Planning Team. These team members should include people who can support you in setting your goals and planning for your future in each of the key areas of transitional care. These individuals may be your parent(s) or guardian(s) or substitute decision maker; other members of your family; your health care team; and/or other support staff important to you and your family. When appropriate, these team members, as well as your anticipated adult health care providers may be asked to participate in Transition Plan meetings.

Your Transition Planning Team will help you to develop goals, identify challenges, create solutions and establish links with community resources in an effort for you to achieve your goals.

The team will be responsible for:

- Assist you with the development of the transition plan
- Monitor the progress of the transition plan
- Organize meetings and visits to the Transition Planning Clinic

Ultimately, you and your family will be responsible for updating and managing any care plans or goals that have been developed during your visits to the Transition Planning Clinic.

Step 2 – Gathering Information

Gathering information about your preferences, strengths, goals, community connections, communication style, and your health and medical needs is an important part of making sure your plan reflects the future you are wanting.

Please take a moment to answer the following questions to allow your Transition Planning Team an opportunity to get to know you and your family.

What are my strengths and interests?

_____

_____

_____

_____

What are my likes and dislikes? (Re. Personal care, communication)

_____

_____

_____

_____

How do I communicate with people?

_____

_____

_____

_____

What services and/or supports do I currently use? (Please complete the 'Health Care Teams and Extended Health Care Team & Additional Supports' list). If you already have an up-to-date list of all care providers and supports involved with you and your family, please bring this information to your first appointment in the Transition Planning Clinic.

What services and/or supports will I still need when I turn 18?

Questions for Your Caregiver(s)

What can I do to help my son or daughter prepare for adult life?

What support can I offer that will help my son or daughter make this transition?

What funding resources do I currently use for my teen's health care needs? (Please complete the 'My Current Financial Resources' sheet) If you already have an up-to-date list of all financial resources you access regarding your child's health care needs, please bring this information to your first appointment in the Transition Planning Clinic.

What services and supports do we need to assist us as a family during our teen's transition to become an adult? (i.e. Home renovations, respite, funding)

Self Assessment & Caregiver(s) Assessment Questionnaire's

Now that you have completed the questions above, please take a few minutes to complete the 'Transition Readiness Checklist. One is for the person with Epilepsy and one is for the Caregiver. These checklists are included in your package.

These questionnaires will help the Transition Planning Team better understand your current needs and the goals for your future.

Health Care Teams

As an initial step in the transition process we need to identify all the Specialists **currently** involved in your care. To the best of your knowledge list the Specialists (MD's, NP's, Nurse Case Manager's etc.) and services involved with your care. If you have not recently seen the specialist please provide an estimate of the last clinic visit date. Completion of this list will help with ensuring that all of your health needs are met once the transition process is complete.

Health Care Team/Specialist	Name of Specialist or Team	Estimated date of last clinic visit
Community Paediatrician		
Family Doctor		
Neurology		
Other		

My Extended Health Care Team & Additional Supports

(Consider adding any care providers you feel are part of your health care team such as Social Worker; community nursing agencies; CCAC case manager; PT; OT; SLP; Resource Worker)

Contact: _____

Position: _____

Agency/Organization: _____

Phone:

Contact:

Position:

Agency/Organization:

Phone:

Current Financial Resources

Funding Source:

Contact:

Phone:

Reason for use:

Funding Source:

Contact:

Phone: _____

Reason for use: _____

Notes