**Transition care plan**

This is an example of a comprehensive transition care plan. Some aspects of the plan may not be relevant to you or your young person and may be removed as needed. The transition care plan template serves as a guide to the considerations that should be made during the transition process.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Surname**  Click here to enter text. | **First name**  First name | **Date of birth**  Click here to enter a date. | **Age**  Age | **Gender assigned at birth**  Choose an item. | | **Pronouns**  Choose an item. | **Gender**  Choose an item. |
| **Paediatric Medical Record Number (MRN)**  Click here to enter text. | **Adult Medical Record Number (MRN)**  Please specify which LHD. | **Medicare number**  Click here to enter text.  Expiry date: Click here | **Address**  Click here to enter text. | | | **Local health district/s (LHD)**  Click here to enter text. | |
| **Aboriginal and/or Torres Strait Islander:**  Choose an item.  **Refugee or asylum seeker:**  Choose an item.  **Other priority population:** Choose an item. | | | **Interpreter:** Choose an item. **Language:** Click here to enter text.  **Help required with communication:** Parent, guardian or patient? | | | | |
| **Patient Contact Details**  **Email:** Click here to enter text.  **Mobile**: Click here to enter text. | | **Parent/carer:** Click here to enter text.  **Email:** Click here to enter text.  **Mobile:** Click here to enter text.  **Home phone:** Click here to enter text. | | | **Parent/carer:** Click here to enter text.  **Email:** Click here to enter text.  **Mobile:** Click here to enter text. | | |
| **Chronic condition/s**  *Click here to enter text* | | | **Current medications**  *Click here to enter text* | | | | |
| **Priorities for transition**  Referral for..,day program, study etc. | | | **Patient goals**  Go to adult appointments, self-manage medications and appointments etc. | | | | |
| **Allergies:** Click here to enter text.  **Immunisations:** Up to date, needs booster etc.  **Precautions:** Click here to enter text. | | | **Weight:** kg. dd/mm/yy **Height:** cm  **Wheelchair weight:** Click here to enter text. | | | | |
| **NDIS:** no/ yes + contact details  **Guardianship:** Choose an item.  **Patient own Medicare Card:** Choose an item.  **Electoral roll:** Choose an item.  **Financial support:** Choose an item.  **Plans:** Choose an item. | | | **Equipment**  Click here to enter text. | | | | |
| **Transition care coordinator/facilitator details**  Name and role  **Email:** Click here to enter text.  **Mobile**: Click here to enter text. | | |  | | | | |

**Individual transfer information**

|  | **PAEDIATRIC TEAM** | | **ADULT TEAM** | | **Comments**  **Referral made:**  Yes (dd/mm/yy)  No  Pending  Not applicable  **Date of 1st appointment:** |
| --- | --- | --- | --- | --- | --- |
| **Role** | **Name** | **Contact details** | **Name** | **Contact details** |  |
| General practitioner (GP) |  |  |  |  |  |
| General paediatrician |  |  |  |  |  |
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