**Transition Readiness Assessment Questionnaire (TRAQ)**

**Patient Name: Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_Today’s Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_ (MRN# )**

***Directions to Youth and Young Adults:*** Please check the box that best describes ***your*** skill level in the following areas that are important for transition to adult health care. There is no right or wrong answer and your answers will remain confidential and private. ***Directions to Caregivers/Parents:*** If your youth or young adult is unable to complete the tasks below on their own, please check the box that best describes ***your*** skill level. **Check here** if you are a parent/caregiver completing this form.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | ***No,******I do not******know how*** | ***No, but I want to learn*** | ***No, but I am learning to do this*** | ***Yes, I have started doing this*** | ***Yes, I always do this when I need to*** |
| ***Managing Medications*** |
| 1. Do you fill a prescription if you need to?
 |   |   |   |   |   |
| 1. Do you know what to do if you are having a bad reaction to your medications?
 |   |   |   |   |   |
| 1. Do you reorder medications before they run out?
 |   |   |   |   |   |
| 1. Do you explain any medications (name and dose) you are taking to healthcare providers?
 |   |   |   |   |   |
| 1. Do you speak with the pharmacist about drug interactions or other

concerns related to your medications? |   |   |   |   |   |
| ***Appointment Keeping*** |
| 1. Do you call the doctor’s office to make an appointment?
 |   |   |   |   |   |
| 1. Do you follow-up on referrals for tests or check-ups or labs?
 |   |   |   |   |   |
| 1. Do you arrange for your ride to medical appointments?
 |   |   |   |   |   |
| 1. Do you call the doctor about unusual changes in your health (for example: allergic reactions)?
 |   |   |   |   |   |
| ***Tracking Health Issues*** |
| 1. Do you fill out the medical history form, including a list of your allergies?
 |   |   |   |   |   |
| 1. Do you keep a calendar or list of medical and other appointments?
 |   |   |   |   |   |
| 1. Do you tell the doctor or nurse what you are feeling?
 |   |   |   |   |   |
| 1. Do you contact the doctor when you have a health concern?
 |   |   |   |   |   |
| 1. Do you make or help make medical decisions pertaining to your health?
 |   |   |   |   |   |
| 1. Do you attend your medical appointment or part of your appointment by yourself?
 |   |   |   |   |   |
| ***Talking with Providers*** |
| 1. Do you ask questions of your nurse or doctor about your health or health care?
 |   |   |   |   |   |
| 1. Do you answer questions that are asked by the doctor, nurse, or clinic staff?
 |   |   |   |   |   |
| 1. Do you ask your doctor or nurse to explain things more clearly if you do not understand their instructions to you?
 |   |   |   |   |   |
| 1. Do you tell the doctor or nurse whether you followed their advice or recommendations?
 |   |   |   |   |   |
| 1. Do you explain your health history to your healthcare providers (including past surgeries, allergies, and medications)?
 |   |   |   |   |   |
| ***Please circle how you feel about the following statements*** |
|   | Not at all important | Not too important | Somewhat important | Important | Very Important |
| How important is it to you to manage your own health care? | 1 | 2 | 3 | 4 | 5 |
| How confident do you feel about your ability to manage your own health care? | 1 | 2 | 3 | 4 | 5 |