**Transition to Adult Congenital Heart Disease Services**

**A Transition Assessment for Early Stage Transition**

**(ages 13 years to 14 years)**

***To be completed and updated by the Transition Nurse***

**Name:** Click or tap here to enter text.

**Hospital Number:** Click or tap here to enter text.

**Hospital Referred from:** Click or tap here to enter text.

**Lead Paediatric Cardiologist:** Click or tap here to enter text.

**Referral Received: Yes  No**

**Date of referral:** Click or tap to enter a date.**:**

**Contact List of relevant health professionals involved**

|  |  |  |
| --- | --- | --- |
| **MDT** | **Name** | **Contact details** |
| Transition Nurse  (Key worker) |  |  |
| Paediatric Cardiologist |  |  |
| Dietician |  |  |
| Social Worker |  |  |
| Clinical Psychologist |  |  |
| Play Specialist |  |  |
| GP |  |  |
| School Nurse |  |  |
| Careers Connect |  |  |
| Learning Disability  Team |  |  |
| Other(s) |  |  |

**Early Stage Transition (age 12 years and up to age 14 years)**

**Transition Appointments**

|  |  |  |
| --- | --- | --- |
| **Date** | **Where** | **With whom** |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** | **N/A** | **Not able to do yet** | **Able to do** | **Date** |
| Understands what Transition is |  |  |  |  |
| Introduced to their Transition Nurse |  |  |  |  |
| Has had their heart condition explained to them |  |  |  |  |
| Has had an explanation of the operations/procedures that they had as a child |  |  |  |  |
| Explanation of the medicines they take and what they are for |  |  |  |  |
| Understands about endocarditis and how to reduce their risks |  |  |  |  |
| Discussed risk taking behaviours  Detail:  Alcohol  Drugs  Smoking  Other |  |  |  |  |
| Understand the importance of exercise and activity |  |  |  |  |
| Managing at school |  |  |  |  |
| Know what they want to do when they leave school |  |  |  |  |
| Have friends they see outside of school |  |  |  |  |
| Have someone they can talk to about how they are feeling and how they are coping with things |  |  |  |  |
| Would like to see someone without their parents |  |  |  |  |
| If not met – please discuss actions taken and any MDT referrals made | | | | |

**Hand-held notes given to patient**  Yes  No

**Signatures: Date:** Click or tap to enter a date.

**Healthcare Professional:**

**Patient:**