**TRANSFER OF CARE TO ADULT SERVICES (AGE 16/18 YEARS)**

**To be completed by ACHD Nurse**

***Pathway to follow patient for at least first 6 – 12months or first 2 appointments***

|  |  |
| --- | --- |
| ACHD Team | Date |
| Accepting Consultant (ACHD) Click or tap here to enter text. | Click or tap to enter a date. |
| ACHD Nurse Specialist Click or tap here to enter text.  | Click or tap to enter a date. |
| Referral received  | Click or tap to enter a date. |
| Documentation received | Click or tap to enter a date. |

**ACHD Appointments:**

1st Appt Date Click or tap to enter a date. Attended Yes [ ] No[ ]

2nd Appt Date Click or tap to enter a date. Attended Yes [ ] No[ ]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** | **N/A** | **Not able to do yet** | **Able to do** | **Date** |
| Adjusting to adult services |  |  |  |  |
| Able to express concerns |  |  |  |  |
| Able to express their views on their transition to adult services |  |  |  |  |

|  |
| --- |
| **Patients thoughts about their transition** |
|  |
| **Family/Parents thoughts about transition** |
|  |

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

**Healthcare Professional:**

**Patient:**