BC Children's Hospital · Provincial Health Services Authority (Province-wide solutions. Better health.) · Vancouver Coastal Health · Providence Health Care (How you want to be treated.) · fraserhealth (Better health. Best in health care.) · island health · northern health (the northern way of caring)

ON TRAC TRANSITION CLINICAL PATHWAY (COMPLEX) NEUROMUSCULAR DISEASES

DATE INITIATED ___/___/_____ DD MM YYYY   DATE LAST CLINIC VISIT ___/___/_____ DD MM YYYY

Preferred Name____

Date of Birth ____________________PHN#___________________

Initiating Clinic____

Diagnosis - Primary_______________________________________

Secondary ____

Secondary ____

Secondary ____

Youth Email____

Youth Cell #____

Mailing Address____

Contacts

Preferred Contact ____

Phone ____

Special Considerations

Need Interpreter Yes__ Language_____________ Non-verbal _____

Safety____

Mobility____

Behavior Concerns ______ Autism _________ Aggressive _______

Current School____

Cognitive Level at grade level Yes ❑ No ❑

Individual Education Plan (IEP) Yes ❑ No ❑

Psycho-educational/Cognitive Assessment (Month/Year)__________

Post-secondary Plans School_____ Work _____ Other_____

First Nations Status No ❑ Yes ❑ Number ________________

Financial/Medication Assistance Yes ❑ No ❑

Contact____

MSP❑ Fair Pharmacare❑ Non-Insured Health Benefits (NIHB)❑

Extended Health Benefits ___________________________________

Advanced Directives _______________________________________

Eligibility CLBC❑ CSIL❑ PWD❑

Transfer Information Checklist

*These people have been sent the **most recent attachments** (where applicable):*	Youth/ Family	Family Practitioner	Adult Specialist
Medical Transfer Summary			
Neuromuscular clinic report			
Physiotherapy report and plan			
Occupational Therapy report			
Orthopedic report			
Reports (PFT, Sleep studies, Respirology /Home Ventilation Team)			
ECHO/ Cardiology report			
Endocrinology report			
Bone Density report			
Ophthalmology report			
Molecular Genetics results			
Nerve Conduction study report			
Spine x-ray			
Muscle Biopsy			
Individual Care Plans (Nursing Support)			
Individual Education Plan (IEP)			
Psycho-educational Assessment (if applicable)			
Transition Care Management Plans			

Consents

I agree to be contacted about my transition experience up to five years after leaving BC Children's Hospital

Youth Signature ______________________________________

Date ______________________________

Or Guardian/Representative Signature______________________________

Youth's strengths and concerns on transfer (to be completed by youth, parent/family and/or health care team)

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____

Pediatric Health Care Team & Recommendations

Family Practitioner ______________________________ Phone# ____________________ Fax# ________________
Address ____
Frequency of visits __________ Purpose ____

Pediatric Specialist (s) ____________________________ Phone# ____________________ Fax# ________________
Date of First Visit ____________________________ **Type of Specialist** ______________________________
Address ____
Frequency of visits __________ Purpose ____

Pediatric Specialist (s) ____________________________ Phone# ____________________ Fax# ________________
Date of First Visit ____________________________ **Type of Specialist** ______________________________
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Pediatric Specialist (s) ____________________________ Phone# ____________________ Fax# ________________
Date of First Visit ____________________________ **Type of Specialist** ______________________________
Address ____
Frequency of visits __________ Purpose ____

Physiotherapist ____________________________ Phone# ____________________ Fax# ________________
Address ____
Frequency of visits __________ Purpose ____

Occupational Therapist ________________________ Phone# ____________________ Fax# ________________
Address ____

Dietician______________________________ Phone# ____________________ Fax# ________________
Address ____

Dentist______________________________ Phone# ____________________ Fax#________________
Address ____

Community Social Worker ________________________Phone# ____________________ Fax# ________________
Email ________________________ Role ____

Child & Youth Special Needs ________________________Phone# ____________________ Fax# ________________
Email ________________________ Role ____

Nursing Support Services ________________________ Phone# ____________________ Fax# ________________
Email ________________________ Role ____

At Home Program ________________________ Phone# ____________________ Fax# ________________
Email ________________________ Role ____

Community Navigator ________________________ Phone# ____________________ Fax# ________________
Email ________________________ Role ____

Adult Health Care Team & Recommendations

Family Practitioner ______________________ Phone# ____________ Fax# __________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Neurologist ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Physiatrist ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Respirologist ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Cardiologist ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Endocrinology ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________ **Type of Specialist** ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Specialist (s) ______________________ Phone# ____________ Fax# __________
Date of First Visit ______________________ **Type of Specialist** ______________________
Address ____
Frequency of visits ________ Purpose ______________________________

AYA GF Strong ______________________ Phone# ____________ Fax# __________
Address ____
Frequency of visits ________ Purpose ______________________________

Adult Occupational Therapist ______________________ Phone# ____________ Fax# __________
Address ____

Adult Dietician ______________________ Phone# ____________ Fax# __________
Address ____

Dentist ______________________ Phone# ____________ Fax# __________
Address ____

CLBC Facilitator ______________________ Phone# ____________ Fax# __________
Address ____
Frequency of visits ________ Purpose ______________________________

Health Case Manager ______________________ Phone# ____________ Fax# __________

Address ____

Purpose ____

Transition Clinical Pathway – User Key **Provider Initial** in ❑ when discussed **C -** 'Complete' **IP -** 'In Progress' – content to review at next visit **N/A -** 'Not Applicable' **Comments -** as required, or expanded in Transition Progress or Nursing Notes	
www.ontracbc.ca -The **Youth and Family Toolkits** provide corresponding ON TRAC learning activities and resources for **ALL** of the indicators listed on the **Transition Clinical Pathway(s).**	The **Complex Transition Clinical Pathway** has been developed for youth who have complex health conditions including 2+ conditions and possibly cognitive, physical and emotional special needs. The goal is for youth to be engaged in their transition planning to the best of their ability and capacity, and where needed, assisted by others.

Team	**Early** 12-14yrs	**Middle** 15-16 yrs	**Transfer** 17-18 yrs	**Adult Care** 19-24 yrs	**Comments**
Identifies a family member, friend and/or advocate who will support youth through health care visits & transition		❑	❑	❑	
Confirms Family Practitioner (FP) and visits at least twice a year for primary care, ongoing care management, referrals, prescription refills, birth control or counselling	❑	❑	❑	❑	
Identifies Adult physicians, clinics and/or teams, how often to see them and for what			❑	❑	
Advocacy	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	**Comments**
Describes and names health condition(s)	❑	❑	❑	❑	
Asks questions and seeks out health care and transition information	❑	❑	❑	❑	
Knows symptoms to report when youth getting sick or having complications from condition(s)		❑	❑	❑	
Aware of possible future health and late effects of condition and/or treatments			❑	❑	
Understands the change in access to information, decision-making and providing consent as the youth reaches adulthood (Representation Agreements)			❑	❑	
Independent Behaviours / Self or Shared Management	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	**Comments**
Assesses youth's abilities and expectations for self-care or directing others	❑	❑	❑	❑	
Knows allergies to medications, food and/or other	❑	❑	❑	❑	
Names medications, how taken, reasons for them and their side effects	❑	❑	❑	❑	
Knows when and how to fill medication(s) prescriptions		❑	❑	❑	
Knows reasons for all tests (including blood tests) and how to access results			❑	❑	
Describes emergency plan – who to call for what, carries emergency information and/or medic-alert	❑	❑	❑	❑	
Knows how to make, why to keep and how to get to health care appointments		❑	❑	❑	
Keeps a personal health record – gets copies of letters,			❑	❑	

reports and assessments					
Visits online toolkits and completes Youth Quiz and/or Parent & Family Checklist at www.ontracbc.ca	❑	❑	❑	❑	

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Comments - as required, or expanded in Transition Progress Notes

Social Supports	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	**Comments**
Discusses youth/parent/family concerns for transition		❑	❑	❑	
Identifies ways family and others can support youth through transition		❑	❑	❑	
Describes activities, recreation, camps and sports outside of school	❑	❑	❑	❑	
Discusses any risks for bullying (in person or online)	❑	❑	❑	❑	
Builds a personal network of friends, peers and mentors with common interests	❑	❑	❑	❑	
Explores if youth is feeling sad, depressed, anxious, hopeless or has difficulty sleeping	❑	❑	❑	❑	
Identifies groups and workshops about transition and planning for adulthood	❑	❑	❑	❑	
Educational / Vocational Plan	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	**Comments**
Discusses school attendance, strengths, goals and/or concerns –may have an Individual Education Plan (IEP)	❑	❑	❑	❑	
Understands how condition(s) may affect career choices – need for Psycho-educational/Cognitive Assessment			❑	❑	
Has a birth certificate, Proof of citizenship, BC I.D. card and Social Insurance Number (SIN)		❑	❑	❑	
Discusses working for service hours, volunteering and paid employment		❑	❑	❑	
Describes visions for after high school: education, work, vocational programs			❑	❑	
Aware of accessibility to scholarships, bursaries, career counselling and/or disability programs			❑	❑	
Registers with College/University student services for special accommodation (for assistance, access or illness)			❑	❑	
Identifies health care to plan for when moving out of home for work, school or travel			❑	❑	
Living / Financial Plan	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	**Comments**
Reviews Transition Timelines for accessing services in the Family Toolkit at www.ontracbc.ca	❑	❑	❑	❑	
Understands eligibility and completes applications for adult home care and services (CLBC, PWD, CISL)		❑	❑	❑	
Discusses financial concerns for out-of-plan medications, equipment, and home support/living/personal care			❑	❑	
Applies for MSP, Fair Pharmacare, dental and extended health or non-insured health benefits			❑	❑	
Initiates financial tools as appropriate: Tax credits, Bank account for 'Persons with Disabilities' (PWD), Registered Disability Savings Plan (RDSP), Registered Education		❑	❑	❑	

Savings Plan (RESP), Will and Estate planning					
Plans for guardianship and future financial planning; Representation Agreement, Will & Estate Planning			❑	❑	

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Comments - as required, or expanded in Transition Progress Notes

Healthy Relationships	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	Comments
Discusses changes in body, hygiene, and menstruation – impact of condition(s)/disability	❑	❑	❑	❑	
Identifies who to talk to about healthy relationships, risks of sexual abuse/exploitation, body boundaries and appropriate touching	❑	❑	❑	❑	
Knows how to prevent pregnancy and sexually transmitted infections (STIs)		❑	❑	❑	
Discusses condition-specific issues for sexual activities, fertility and child-bearing		❑	❑	❑	
Understands need for and access to genetic counselling			❑	❑	

Personal Health & Safety	12-14yrs	15-16 yrs	17-18 yrs	19-24 yrs	Comments
Describes regular physical activity and any restrictions due to condition	❑	❑	❑	❑	
Describes healthy weight, special diets or concerns	❑	❑	❑	❑	
Discusses interactions of alcohol, drugs, smoking with medications and health www.drugcocktails.ca		❑	❑	❑	
Discusses driving and aware of any restrictions – other means of transportation		❑	❑	❑	

Checklist	Pre-Transfer
	Youth/Family Questionnaires ❑ Confirmed next FP visit ❑ Scheduled Last Pediatric Visit(s) ❑
	Transition Workshop ❑ Booked Appointment(s) to Adult Specialist(s) ❑ Service Application(s) completed ❑
	Outstanding concerns:
	Post-Transfer
	FP received Transfer Package* ❑ Adult Specialist(s) received Transfer Package* ❑
	Youth attended Adult Clinic – First Visit ❑ Second Visit ❑ Adult Consult Letter back to Pediatric Clinic & FP ❑
	***Transfer Package includes – Medical Transfer Summary, Transition Clinical Pathway and condition-specific documents, reports & assessments (as indicated on front sheet).**

Initial	Signature / Role

Transition Progress Notes:

Condition-specific Information	
Adult Team & Care providers	
Self or Shared Health Management	
Financial/ Living	

Transition Progress Notes:	
Education/ Vocation	
Peer Support, Recreation & Leisure	
Sexual Health	
Safety	