

**ON TRAC TRANSITION CLINICAL PATHWAY (COMPLEX)
HEMOPHILIA & HEMOGLOBINOPATHIES**

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

Preferred Name _____
 Date of Birth _____ PHN# _____
 Initiating Clinic _____
 Diagnosis Primary _____
 Secondary _____
 Youth Email _____
 Youth Cell # _____
 Mailing Address _____

Contacts
 Preferred Contact _____
 Phone _____
 Emergency Contact (if different) _____
 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 | | | |
|---|------------------|------------------------|---------------------|
| <i>These people have been sent the most recent attachments (where applicable):</i> | Youth/ Family | Family Practitioner | Adult Specialist |
| Medical Transfer Summary | | | |
| Condition-specific Flow Sheets | | | |
| Psychology Assessment | | | |
| Psycho-educational/Cognitive Assessment | | | |
| Social Work Assessment | | | |
| Speech/Language Plans | | | |
| Physiotherapy Report and Plan (Last Visit) | | | |
| Occupational Therapy Report | | | |
| Relevant Recent Reports (Reports & imaging) | | | |
| Relevant Recent Reports (Labs & Genotyping) | | | |
| Individual Education Plan (IEP) | | | |
| Individual Care Plans (Nursing Support) | | | |
| Infusion Diaries | | | |
| Prescriptions (Most Recent) | | | |
| Transition Care Management Plans | | | |
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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)

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# _____

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Address _____

Frequency of visits _____ Purpose _____

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 _____

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|---|--|
| Adult Health Care Team & Recommendations | |
| Family Practitioner _____ Phone# _____ Fax# _____ Address _____ Frequency of visits _____ Purpose _____ | |
| Adult Specialist (s) _____ 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 _____ | |
| Adult Specialist (s) _____ Phone# _____ Fax# _____ Date of First Visit _____ Type of Specialist _____ Address _____ Frequency of visits _____ Purpose _____ | |
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| Adult Specialist (s) _____ Phone# _____ Fax# _____ Date of First Visit _____ Type of Specialist _____ Address _____ Frequency of visits _____ Purpose _____ | |
| Adult Physiotherapist _____ 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 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 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Confirms Family Practitioner (FP) and visits at least twice a year for primary care, ongoing care management, referrals, prescription refills, birth control or counselling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Identifies Adult physicians, clinics and/or teams, how often to see them and for what | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Advocacy | 12-14yrs | 15-16 yrs | 17-18 yrs | 19-24 yrs | Comments |
| Describes and names health condition(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Asks questions and seeks out health care and transition information | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows symptoms to report when youth getting sick or having complications from condition(s) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Aware of possible future health and late effects of condition and/or treatments | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understands the change in access to information, decision-making and providing consent as the youth reaches adulthood (Representation Agreements) | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows allergies to medications, food and/or other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Names medications, how taken, reasons for them and their side effects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows when and how to fill medication(s) prescriptions | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows reasons for <u>all</u> tests (including blood tests) and how to access results | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Describes emergency plan – who to call for what, carries emergency information and/or medic-alert | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows how to make, why to keep and how to get to health care appointments | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Keeps a personal health record – gets copies of letters, reports and assessments | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Visits online toolkits and completes Youth Quiz and/or Parent & Family Checklist at www.ontracbc.ca | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| Transition Clinical Pathway – User Key | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|
| Provider Initial in <input type="checkbox"/> 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 Notes | | | | | |
| Social Supports | 12-14yrs | 15-16 yrs | 17-18 yrs | 19-24 yrs | Comments |
| Discusses youth/parent/family concerns for transition | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Identifies ways family and others can support youth through transition | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Describes activities, recreation, camps and sports outside of school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses any risks for bullying (in person or online) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Builds a personal network of friends, peers and mentors with common interests | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Explores if youth is feeling sad, depressed, anxious, hopeless or has difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Identifies groups and workshops about transition and planning for adulthood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understands how condition(s) may affect career choices – need for Psycho-educational/Cognitive Assessment | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Has a birth certificate, Proof of citizenship, BC I.D. card and Social Insurance Number (SIN) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses working for service hours, volunteering and paid employment | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Describes visions for after high school: education, work, vocational programs | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Aware of accessibility to scholarships, bursaries, career counselling and/or disability programs | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Registers with College/University student services for special accommodation (for assistance, access or illness) | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Identifies health care to plan for when moving out of home for work, school or travel | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understands eligibility and completes applications for adult home care and services (CLBC, PWD, CSIL) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses financial concerns for out-of-plan medications, equipment, and home support/living/personal care | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Applies for MSP, Fair Pharmacare, dental and extended health or non-insured health benefits | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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 | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Plans for guardianship and future financial planning; Representation Agreement, Will & Estate Planning | | | <input type="checkbox"/> | <input type="checkbox"/> | |

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|--|--|--------------------------|--------------------------|--------------------------|-----------------|
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| Provider Initial in <input type="checkbox"/> 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 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Identifies who to talk to about healthy relationships, risks of sexual abuse/exploitation, body boundaries and appropriate touching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Knows how to prevent pregnancy and sexually transmitted infections (STIs) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses condition-specific issues for sexual activities, fertility and child-bearing | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Understands need for and access to genetic counselling | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Describes healthy weight, special diets or concerns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses interactions of alcohol, drugs, smoking with medications and health www.drugcocktails.ca | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Discusses driving and aware of any restrictions – other means of transportation | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Checklist | Pre-Transfer | | | | |
| | Youth/Family Questionnaires <input type="checkbox"/> Confirmed next FP visit <input type="checkbox"/> Scheduled Last Pediatric Visit(s) <input type="checkbox"/> | | | | |
| | Transition Workshop <input type="checkbox"/> Booked Appointment(s) to Adult Specialist(s) <input type="checkbox"/> Service Application(s) completed <input type="checkbox"/> | | | | |
| | Outstanding concerns: | | | | |
| | Post-Transfer | | | | |
| | FP received Transfer Package* <input type="checkbox"/> Adult Specialist(s) received Transfer Package* <input type="checkbox"/> | | | | |
| | Youth attended Adult Clinic – First Visit <input type="checkbox"/> Second Visit <input type="checkbox"/> Adult Consult Letter back to Pediatric Clinic & FP <input type="checkbox"/> | | | | |
| | *Transfer Package includes – Medical Transfer Summary, Transition Clinical Pathway and condition-specific documents, reports & assessments (as indicated on front sheet). | | | | |
| Initial | Signature / Role | | | | |
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| 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 | |