**Patient Name:** _____ **Date of Birth:** ___/___/___ **Today's Date** ___/___/___ **(MRN#** _____**)**

# Transition Readiness Assessment Questionnaire (TRAQ)

***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? | | | | | |
| 2. Do you know what to do if you are having a bad reaction to your medications? | | | | | |
| 3. Do you take medications correctly and on your own? | | | | | |
| 4. Do you reorder medications before they run out? | | | | | |
| ***Appointment Keeping*** | | | | | |
| 5. Do you call the doctor's office to make an appointment? | | | | | |
| 6. Do you follow-up on any referral for tests, check-ups or labs? | | | | | |
| 7. Do you arrange for your ride to medical appointments? | | | | | |
| 8. Do you call the doctor about unusual changes in your health (For example: Allergic reactions)? | | | | | |
| 9. Do you apply for health insurance if you lose your current coverage? | | | | | |
| 10. Do you know what your health insurance covers? | | | | | |
| 11. Do you manage your money & budget household expenses (For example: use checking/debit card)? | | | | | |
| ***Tracking Health Issues*** | | | | | |
| 12. Do you fill out the medical history form, including a list of your allergies? | | | | | |
| 13. Do you keep a calendar or list of medical and other appointments? | | | | | |
| 14. Do you make a list of questions before the doctor's visit? | | | | | |
| 15. Do you get financial help with school or work? | | | | | |
| ***Talking with Providers*** | | | | | |
| 16. Do you tell the doctor or nurse what you are feeling? | | | | | |
| 17. Do you answer questions that are asked by the doctor, nurse, or clinic staff? | | | | | |
| ***Managing Daily Activities*** | | | | | |
| 18. Do you help plan or prepare meals/food? | | | | | |
| 19. Do you keep home/room clean or clean-up after meals? | | | | | |
| 20. Do you use neighborhood stores and services (For example: Grocery stores and pharmacy stores)? | | | | | |