Patient Name: _____ Birthdate: _____ Age: _____

Completed By: _____ Date: _____

# Health Management Checklist

This ***Health Management Checklist*** is about the skills that help you take care of your health. Your doctor or nurse will talk with you about the areas where you want help. Please complete this checklist by marking the box or boxes that describe you the best. If you do not understand a question, please ask your nurse or doctor for help.

| ACCESSING HEALTH CARE - Skills and Abilities: | YES, I do | NO, I want to learn | Someone needs to do this for me | N/A, not needed | Need more info |
|---|---|---|---|---|---|
| 1. Do you wear or carry a medical alert (list of allergies, conditions)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Do you speak up for yourself in your doctor's office? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Do you help make health care decisions with your doctor? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Do you see your doctor alone? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Do you know your rights to keep your health information private? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Do you call your doctor(s) on your own if you have a problem? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Do you schedule your doctor appointments? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Do you keep your portable medical summary and/or care plan up to date? | ☐ | ☐ | ☐ | ☐ | ☐ |
| **MANAGING YOUR CONDITIONS AND TREATMENTS - Skills and Abilities:** | | | | | |
| 9. Do you know how to describe your health conditions/disabilities and do you know how they affect your daily life? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Do you know the names of your medicines and why you take them? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Do you know what can happen if you skip your treatments or medicine? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Do you almost always take your medicines correctly on your own? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Do you fill your own prescriptions? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Do you use and take care of your own medical equipment and supplies? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Do you know when to call for routine checkups, urgent care, and when to go to the emergency room or call 9-1-1? | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STAYING HEALTHY - Skills and Abilities:** | | | | | |
| 16. Do you understand how smoking, drinking, and/or using drugs can affect your condition (worsen symptoms, react with your medicines)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Do you know how your condition affects sexuality (quality or state of being sexual, the need for closeness, caring and touch)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Do you know what to do for birth control, safe sex, and reproductive concerns (genetics, pregnancy)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. Do you know how to maintain a healthy lifestyle? | ☐ | ☐ | ☐ | ☐ | ☐ |
| **INSURANCE - Skills and Abilities:** | | | | | |
| 20. Do you know what your health insurance covers (co-pays, referrals)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. Do you know who to call for questions about your insurance coverage? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. Do you know how you will maintain health insurance coverage? | ☐ | ☐ | ☐ | ☐ | ☐ |
| **BENEFITS, SERVICES AND RESOURCES - Skills and Abilities:** | | | | | |
| 23. Do you know of resources that can help you to find needed services (job support, transportation, assistive technology, etc.)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24. Do you know how your condition might affect your employment? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 25. Do you know what government benefits you might qualify for (SSI, SSDI, Health Benefits for Workers with Disabilities, Home & Community Based Services, etc.)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 26. Do you know about guardianship or power of attorney for health care? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 27. Do you know your options for housing (on your own, group home)? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 28. Do you know your options for jobs, education, and recreation? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 29. Do you know how to manage your money and pay your bills? | ☐ | ☐ | ☐ | ☐ | ☐ |

**Office Use:** The ***Health Management Checklist*** can help the clinician assess the patient's level of independence in health care management by evaluating current skill levels, identifying areas for education and practice, and determining areas in which the patient requires continued support.

A checklist such as this can serve as a framework for both the patient and the physician to assess needs and improve communication for health care management. Measure progress by using the same tool at periodic intervals

- Ask new patients ≤ 30 and new patients of any age with disabilities to complete the checklist. Reassess every 12 to 24 months if significant deficits are revealed
- Review progress and recognize success
- Document results and update transition goals

| **Office Use Only** | **Provider Notes:** |
|---|---|
| Reviewed by: Date: | |
| _____ _____ | |
| _____ _____ | |
| _____ _____ | |

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**http://illinoisaap.org/projects/transition/**