Healthcare professionals- Transition pathway checklist

Patient name:
Patient Date of Birth:

Step 1

- [ ] A patient aged 14 years + with a long-term health condition is introduced to the transition process
- [ ] Patient aged 14 years + with long-term health condition given transition leaflet
- [ ] Patient aged 14 years + is signposted to the disease-specific information
- [ ] Inform GP of the transition process and encourage care for minor illnesses
- [ ] Key worker identified and documented in notes
- [ ] Key worker copied into clinic letters

Date completed:
Signed:

Step 2

- [ ] Start patient on transition pathway
- [ ] Patients aged 14 years+ offered the opportunity to be seen alone at each clinic appointment
- [ ] Copy clinic letters to patients or send a separate summary letter

Date completed:
Signed:

Step 3

- [ ] Start transition plan and document in notes
- [ ] Ensure patients and parents have contacts for key team members

Date completed:

Signed:

Step 4

- [ ] CYP with complex health needs and neuro disability - lead consultant identified by 15th birthday
- [ ] Complete health passport by 16th birthday
- [ ] Encourage annual health checks by GP for patients with LD from the 14th birthday

Date completed:

Signed:

Step 5

- [ ] An adult lead consultant identified
- [ ] Complete transition pathway documentation
- [ ] Transfer letter/transition plan includes In Case of Emergency Contact
- [ ] The transition plan is updated and copied to GP, patient, and adult team
- [ ] Signpost patient/carer to information about the adult team

Date completed:

Signed:

Step 6

- [ ] Arrange a visit to the adult outpatient setting
- [ ] Joint clinic planned/held in children's outpatient setting
- [ ] Update consent and confidentiality
- [ ] Ensure updated EMHCP and provide detailed handover to adult service

Date completed:

Signed:

Step 7

- [ ] Plan with the patient a route into urgent care
- [ ] Opportunity for the young person to visit acute adult inpatient areas
- [ ] Copy GP into the plan for a route into urgent care
- [ ] Complex patients requiring multiple specialities have follow-up arranged with MDT to plan a route into urgent care

Date completed:

Signed:

Step 8

- [ ] Transfer letter updated and completed
- [ ] Transition documentation fully completed
- [ ] GP, key worker, and patient copied into an updated letter

Date completed:

Signed:

Step 9

☐ Start hello to adult services pathway

☐ Joint clinic planned/held in an adult clinic setting

☐ Update consent and confidentiality

Date completed:

Signed:

Step 10

☐ DNA letter to paediatric service, GP, parent, and patient if the patient does not attend

☐ Post-transfer transition questionnaire sent to patient 6 months after the transfer

Date completed:

Signed: