Child Health and Wellbeing Network

Transition discussion / letter template

Young person's name (parents' / carers' names)

Young Person name and parents'/Carers names	
Next of kin name and contact details	
School/college and contact details	
Disability social worker name and contact details	

Registers and flags

- **Should the young person be included on any practice registers or summary care record flags?** e.g. learning disability, palliative care, reasonable adjustment flag

Health overview

Diagnoses (including medical diagnoses, learning disability, neurodivergence or suspected autism)

- **Main diagnoses** (onset of symptoms)
  - For each diagnosis include First presentation/ Changes over time/ clinician input
- **Past diagnoses**
  - Resolved issues / previous investigations/treatments

Current progress

Detail of last clinic encounter and review plans

- Status of conditions
- What needs progressing going forward?
- What is already settled?
- Plans for follow up and adult service referrals
- Recommendations for GP role in ongoing review

Medications

- Current treatment with doses
- Medications recently discontinued
- OTC/other medications or treatments
- Consider formulation of medication/brand name prescribing as necessary
- Any allergies

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Current/ongoing Management of Healthcare

Role	Name and contact details	Transferring care to	Role	Name and contact details	Further actions needed	Action owner
Medical teams						
GP		→				
Community paediatrician		→				
Tertiary neurodisability paediatrician		→				
Tertiary neurology paediatrician		→				
Other paediatric teams, e.g, gastroenterology, respiratory, home ventilation		→				
Orthopaedics/spinal team		→				
Neurosurgeons/ENT		→				
CAMHS		→				

Role	Name and contact details	Transferring care to	Role	Name and contact details	Further actions needed	Action owner
Therapy teams and allied health professionals						
Physiotherapist		→				
Occupational therapist		→				
Speech and language therapist		→				
Dietician		→				

Role	Name and contact details	Transferring care to	Role	Name and contact details	Further actions needed	Action owner
Specialist nursing teams						

Community Children's Nurses		→				
Learning Disability specialist nurse		→				
Epilepsy specialist nurse		→				

Role	Name and contact details	Transferring care to	Role	Name and contact details	Further actions needed	Action owner
Other community services						
E.g., vision, hearing, dentist		→				

Role	Name and contact details	Transferring care to	Role	Name and contact details	Further actions needed	Action owner
Equipment services						
E.g., wheelchair, orthotics, communication aids		→				

Care plans and other documents

Reasonable Adjustments

- Any reasonable adjustments needed/currently in place
- Poverty Proofing considerations
- Level of participation in decision-making

Does the young person have any of the following documents;

Document	Available	Lead contact / contact details	Location of document
Learning Disability AHC	No		
Education Health and Care Plan	No		
Emergency healthcare plan	No		
Treatment escalation plan	No		
DNACPR	No		
Hospital passport	No		

Condition or symptoms -specific care management plan (e.g. FASD, epilepsy)	No		

For each plan that is in place, include details (date of last review, where plan can be viewed, professional leading on updates, plans to review with adult services)

Current social situation

- Challenges / strengths of the team around the child
- Progress in planning for social care and respite post transition
- Any current or past safeguarding concerns

Education/Employment

Current stage in education system. Qualifications and grades obtained. Future plans beyond current stage in education.

Other issues

New problems under investigation / social dynamics etc

Transition

Preparedness for transition

Clinical team perspective on how prepared for transition the YP is (including knowledge of condition, self-care skills including management of medications, appointments on own or with carer present, etc).

Perspective of young person

Paragraph written by YP about their experience of their illnesses/conditions and what they want to get out of the next year of their treatment/what they are concerned/excited about regarding transition.

Plan from transition discussion (on date x)

Detail of any plans made, including any arranged transition/transfer appointments.

GP role

Detail of any discussions about role of GP including Annual health checks or other follow up