



Readiness Checklist

Patient's Name: Click here to enter text. Date form complete: 2020/Jun/11 Name of Clinic: Click here to enter text. Form completed with assistance (if needed) from: Click here to enter text.	Yes, I do this.	I am learning to do this.	I need to learn how.	Someone else will have to do this (provide name if known).	This does not apply to me.
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1.	I can name and describe my health condition(s) and explain my health care needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I can name my medications and treatments, and what they are for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I can name my allergies and know how they may impact my condition(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I know the doses and the side effects to watch for from my medications and treatments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I prepare and take my medications and/or treatments on my own.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I call in my own prescription refills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I take care of my own medical equipment and supplies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	I organize and keep track of my own health information (i.e. appointments and test results).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	I carry my important health information with me every day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	I know the names of my doctors and therapists.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	I call to book my own healthcare appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	I spend time alone with my healthcare provider at each visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	I make a list of questions I want to ask before each doctor's appointment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	I know what I have for health insurance and carry my health insurance card(s) to appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	I feel ready to make decisions about my own health. I understand I will be the primary decision maker in adult based care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	If I get sick, I know how to get the help that I need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	I know what impact my condition(s) may have on my life in the future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:
[Click here to enter text.](#)

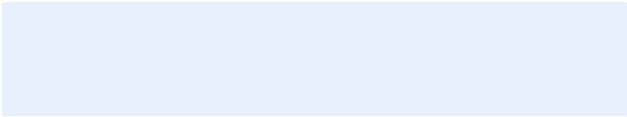




AFFIX PATIENT LABEL

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Signature/Status

Print Name: [Click here to enter text.](#)

