AFFIX PATIENT LABEL

IWK Health Centre

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.
1. I can name and describe my health condition(s) and explain my health care needs.	☐	☐	☐	☐	☐
2. I can name my medications and treatments, and what they are for.	☐	☐	☐	☐	☐
3. I can name my allergies and know how they may impact my condition(s).	☐	☐	☐	☐	☐
4. I know the doses and the side effects to watch for from my medications and treatments.	☐	☐	☐	☐	☐
5. I prepare and take my medications and/or treatments on my own.	☐	☐	☐	☐	☐
6. I call in my own prescription refills.	☐	☐	☐	☐	☐
7. I take care of my own medical equipment and supplies.	☐	☐	☐	☐	☐
8. I organize and keep track of my own health information (i.e. appointments and test results).	☐	☐	☐	☐	☐
9. I carry my important health information with me every day.	☐	☐	☐	☐	☐
10. I know the names of my doctors and therapists.	☐	☐	☐	☐	☐
11. I call to book my own healthcare appointments.	☐	☐	☐	☐	☐
12. I spend time alone with my healthcare provider at each visit.	☐	☐	☐	☐	☐
13. I make a list of questions I want to ask before each doctor's appointment.	☐	☐	☐	☐	☐
14. I know what I have for health insurance and carry my health insurance card(s) to appointments.	☐	☐	☐	☐	☐
15. I feel ready to make decisions about my own health. I understand I will be the primary decision maker in adult based care.	☐	☐	☐	☐	☐
16. If I get sick, I know how to get the help that I need.	☐	☐	☐	☐	☐
17. I know what impact my condition(s) may have on my life in the future.	☐	☐	☐	☐	☐

Notes:
Click here to enter text.

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_____

Signature/Status

Print Name: Click here to enter text.