IWK Health Centre

K07002307 Jun/7/2002 M
SCA,TEST Visit
ER0000145/12 **HCN:** 22222222
Van den Hof, TEST / TEST, Maureen
Dec/8/2012

Readiness Checklist

Patient's Name_____ **Date (dd/mm/yyyy) form completed**_____ **Name of Clinic**_____ **Form completed with assistance (if needed) from**_____		**Yes, I do this.**	**I am learning how 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 healthcare 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:

Signature / Status	**Print Name**	**Initials**