

## READINESS CHECKLIST

Patient's Name: _____ Date (YYYY/MON/DD) 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 that 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: \_\_\_\_\_

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Signature/Status	Print Name	Initials

