Healthcare Transfer Tool

Planning a transfer from paediatric to adult care for young people with intellectual and developmental disabilities

Introduction

Paediatric healthcare providers and family physicians can use this tool to proactively plan a transfer from child to adult providers with their patients with intellectual and developmental disabilities and their families. The form guides a quick review of what is known about the patient's current needs and helps to identify what providers will be needed in the future. It outlines steps to pro-actively address gaps in planning the patient's healthcare transfer.

How to use this tool

A - REVIEW PATIENT NEEDS: Identify services or providers to be included in the transfer plan based on the patient's current needs. It is not necessary to summarize detailed health information. Leave sections blank if unsure and focus on identifying providers and supports that will be needed in the adult system.

B - IDENTIFY GAPS: List all pediatric providers and the expected plan for transfer.

C - PLAN FOR TRANSFER: If a gap is identified in step B, specify how to address this and plan for next steps. Highlight which documents to consider sending to adult providers.

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Surrey Place Developmental Disabilities Primary Care Program

Patient Name		DOB:
First	Last	

A Review patients needs *Review sections below to help identify services and providers to be included in transfer plan and information relevant to include in referrals. Potential services and/or needed professionals are italicized.*

Intellectual and Developmental Disability

- ☐ **Confirmed diagnoses, psychological assessment available**
  - ☐ Mild intellectual disability
  - ☐ Moderate intellectual disability
  - ☐ Severe intellectual disability
  - ☐ Profound intellectual disability
  - ☐ Autism spectrum disorder
  - ☐ Other:
- ☐ **Psychological assessment needed**
  - ☐ For eligibility for services
  - ☐ To clarify diagnosis
  - ☐ Other:

Adaptive Functioning

- ☐ Patient is independent in ADLs and IADLs
- ☐ Independent in ADLS but requires support for instrumental activities of daily living IADLS (eg, finances, scheduling, shopping)
- ☐ Need help (prompting) for some ADLS
- ☐ Needs help with all activities of daily living (ADLS) (dressing, bathing, eating, toileting)
- ☐ **Need for community services/supports** (respite, home care, etc.):
- ☐ **Notes:**

Services, Supports and Funding

Application for adult social services and income supports initiated (eg, in Ontario, Ontario Disability Support Program and Developmental Services Ontario)

☐ Yes ☐ No ☐ Unsure

Notes (eligibility, intake, waitlists, service needed etc.):

Communication

Patient first language:

Caregiver first language:

Notes:

- ☐ Uses a device, board or method other than speech. Alternative augmentative communication (AAC)
- ☐ **Translator needed**
- ☐ **Alternative Augmentative Communication Clinic needed**
- ☐ **Notes:**

Healthcare Decision Making History

- ☐ Has been mostly independent
- ☐ Has needed some help from Substitute Decision Maker (SDM)
- ☐ Has required SDM

SDM has been identified as:

- ☐ **Legal assistance needed to identify SDM or clarify role**

Note: Decision making capacity is decision specific and not static. Patients with IDD should be provided with supports and accommodations to help them to understand and appreciate decisions.[x]

Health information: List in point form diagnoses and active medical concerns requiring ongoing follow-up in adulthood

B. Identify Gaps List all paediatric providers in the left column and the corresponding adult providers in the middle column.		**C. Transfer Plan** If a gap is discovered in adult providers, identify who will address this and the next steps in the plan.
Paediatric Type of Provider: i.e. Primary care, type of specialist, allied health, community services, vision, hearing, dental.	**Adult** Type of Provider: i.e. Primary care, type of specialist, allied health, community services, vision, hearing, dental.	Who will work on this? i.e. Patient, family or a provider.
Primary Care:	Primary Care:	Transfer Plan:
Dentist:–	Dentist:	Transfer Plan:
Provider:	Provider:	Transfer Plan:
Provider:	Provider:	Transfer Plan:
Provider:	Provider:	Transfer Plan:
Provider:	Provider:	Transfer Plan:

B. Identify Gaps List all paediatric providers in the left column and the corresponding adult providers in the middle column.		**C. Transfer Plan** If a gap is discovered in adult providers, identify who will address this and the next steps in the plan.
Paediatric Type of Provider: i.e. Primary care, type of specialist, allied health, community services, vision, hearing, dental.	**Adult** Type of Provider: i.e. Primary care, type of specialist, allied health, community services, vision, hearing, dental.	Who will work on this? i.e. Patient, family or a provider.
Other (i.e. Respite, funding supports, social worker)	Other (i.e Services and funding for adults with disabilities, social worker)	Transfer Plan:
Other (i.e. Allied Health, Community)	Other (i.e. Allied Health, Community)	Transfer Plan:

Records to accompany transfer:

- ☐ Cumulative Patient Profile (CPP) or patient summary (including medications, medical history).
- ☐ Immunization record
- ☐ Key assessments, reports, lab results, notes
- ☐ Genetic assessment report
- ☐ Psychological and functional assessment reports
- ☐ Emergency Care Plan or protocols (eg, seizures)
- ☐ Mental Health Crisis Plan
- ☐ Health Crisis Plan
- ☐ Other:

Notes

Supporting materials

Practice tools

i. **SHARE: Transition Checklist for Youth with IDD and Caregivers**
Developmental Disabilities Primary Care Program of Surrey Place, Toronto, Ontario
https://ddprimarycare.surreyplace.ca/tools-2/general-health/transitions/

ii. **SHARE Transition Plan: Talking about transition with young people with developmental disabilities and their families**
Developmental Disabilities Primary Care Program of Surrey Place, Toronto, Ontario
https://ddprimarycare.surreyplace.ca/tools-2/general-health/transitions/

iii. **Transitioning to Adult Care, Good 2 Go Program [website]**
Hospital for Sick Children, Toronto
http://www.sickkids.ca/patient-family-resources/resource-navigation-service/transitioning-to-adult-care/index.html

iv. **Got Transition [website]**
Center for Health Care Transition Improvement, Washington, DC] https://www.gottransition.org/

References

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