

Self-Assessment of Worries, Concerns, and Burdens Related to Pituitary Hormone Deficiencies and Preparation for Transitioning

BY THE ENDOCRINE SOCIETY

Consider the following statements and note how important it would be to discuss the item with your healthcare team as you are moving on from pediatric to adult endocrinology care.

Patient Name _____ Date _____

GENERAL CONCERNS

YES MAYBE NO

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. I feel confused about managing my hormone deficiencies on my current treatment plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. My medical condition keeps me from doing many things that I want to do in life now. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. I feel "burned out" from daily growth hormone injections. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I feel "burned out" from having to take multiple medications daily. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SOCIAL/EMOTIONAL/COGNITIVE ISSUES

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 5. I have trouble paying attention in class or at work. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I seem to forget things more than most of my friends. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I struggle to keep up with my class work or job responsibilities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Organizing my life every day is a challenge for me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. I do not get along well with classmates and/or co-workers. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I am not able to do things that others my age can do. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. I often feel sad or 'blue'. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. I worry about my future. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. My health conditions make it hard to find a significant other. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. I am worried about how my health conditions will affect my future fertility. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

TRANSITION PREPARATION AND READINESS TO TRANSFER FROM PEDIATRIC TO ADULT CARE

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 15. I know how each of my medications work and what to do if things don't seem to be going right. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. I know what to do with my medications if I get sick. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. I have a MedicAlert™ bracelet or other identifier. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Name _____ Date _____

	YES	MAYBE	NO
18. I can refill a prescription by myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I can make a doctor's appointment by myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I know what my insurance covers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I can get myself to my endocrinology appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. If I need to see a specialist, I know how to find one.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I have a primary care doctor and know how to contact him/her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I have friends or family who can help me with my medical care if I need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I have contacted patient support organizations in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I WOULD LIKE TO TALK ABOUT SOME OF THESE ISSUES

Here are other topics I would like to discuss today _____

Here are other topics I would like to discuss in the future _____



IN COOPERATION WITH



American Academy of Pediatrics



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