The TransitionIBD Flowsheet template is a point-of-care tool, designed to support the transition of patients with IBD from pediatric to adult care. The TransitionIBD Flowsheet template provides the pediatric healthcare team with a checklist of actions and discussion topics to address during the transition process and includes a comprehensive medical summary (e.g., medications, lab results, imaging results, history of medical complications, and current/past psychosocial status). The Transition Letter and Medical Summary sections of this template are to be shared with the adult provider.

When initiating the transition to adult care, it is important to start discussing the transition process early on (around 16-17 years old) with the patient and their caregiver and remind them that you will be revisiting the goals discussed throughout the transition process.

INITIATE TRANSITION		Date (MM/DD/YYYY)
Discuss transition policy with patient and caregiver/parent		
Share TransitionIBD tool with patient		
Discuss goals of transition with patient		
Discuss priority of transfer with patient	☐ Urgent (within 3-months) ☐ Semi-urgent (within 6-months) ☐ Non-urgent (within 12-months or within 6-12 months of 18th birthday)	

Use the counselling points below to prepare the patient to participate in an adult model of care.

ADULT MODEL OF CARE		Date (MM/DD/YYYY)
Confirm adult provider and members of the multidisciplinary team with patient		
Review how to book medical appointments with patient		
Discuss changes in decision making, consent and privacy in an adult model of care		
Discuss options to support decision making with patient		
Discuss where to find information on adult patient support programs with patient		
Review where to find insurance coverage information with patient		
First appointment with adult provider has been confirmed by:	☐ Patient ☐ Adult provider clinic	

The Care Plan provides a comprehensive overview of the patient's disease status, medications, medical history, tests, and complications. It is recommended to review and update the Care Plan at least twice before completing the transfer to adult care.

CARE PLAN	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)
Update Medical Summary section						
Update Medications section						
Discuss Medical Summary and Medications with patient						
Update Surgical History and Complications sections						
Update Imaging and Lab Tests sections						
Discuss recent and/or upcoming tests with patient						
Update Psychosocial and Other sections						

The 'Are You Ready?' quiz helps youth identify the self-care skills needed to independently manage their IBD. The quiz may be repeated as often as is necessary. Use the boxes below to keep track of the dates where you discussed the quiz results and strategies to improve self-management skills with the patient.

SELF CARE SKILLS

	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)
Remind patient to complete 'Are You Ready?' quiz on TransitionIBD tool						
Review quiz results and identify needed self-care skills						
Discuss questions or concerns related to self-management skills						
Discuss tools and strategies to help patient keep track of appointments and medications						

ONGOING CARE	Date (MM/DD/YYYY)
Update contact information for healthcare provider	
Notify patient support program (PSP) of transition and update PSP contact information	
Confirm receipt of 'Plan of Care' and multidisciplinary team contact information by adult provider	

ADULT PROVIDER CONTACT INFORMATION

The patient has been provided the following information regarding the adult provider.

Provider	Phone	Email	Fax	Date (MM/DD/YYYY)
Contact details for office including location and parking details				
Contact details for Nurse				
Contact details for Gastroenterologist				

MULTIDISCIPLINARY TEAM CONTACT INFORMATION

Provider	Name	Phone	Address	Email
Surgeon				
Rheumatologist				
Dermatologist				
Social Worker				
Psychologist/ Psychiatrist				
Dietitian				
Other Provider, specify specialty: _____				

Content in the sections below to be shared with the adult healthcare team before completing transition.

TRANSITION LETTER

Patient name		**Patient biological sex**	
Patient address		**Patient phone #**	
Parent/caregiver name		**Parent/caregiver phone #**	

Transition letter sent to adult centre point of contact (using at least 2 of the 3 methods):			**Date (MM/DD/YYYY)**
☐ Email	☐ Electronic communication	☐ Fax	

The following were copied when sending the letter:			**Date (MM/DD/YYYY)**
☐ Family physician	**Name**		
	Contact details		
☐ Patient/caregiver	**Name**		
	Contact details		
☐ Other specialist involved in care	**Name**		
	Contact details		

Adult provider confirmed receipt via the following methods:		**Date (MM/DD/YYYY)**
☐ Email	☐ Fax	
An appointment has been confirmed with the adult provider	☐ Yes	

Notes from the pediatric patient files were sent to adult provider to complete transfer of care via:	**Date (MM/DD/YYYY)**
☐ Email	
☐ Fax	

The PSP contact was notified of the transfer via:	**Date (MM/DD/YYYY)**
☐ Email	
☐ Fax	

The following were copied when sending the PSP communication:	**Date (MM/DD/YYYY)**
☐ Patient	
☐ Patient/caregiver	
☐ Family physician	
☐ Other specialists involved in care	

The details below were included when notifying the PSP	
☐ Adult gastroenterology point of contact email	☐ Adult gastroenterology point of contact fax #

Provider	**Name**	**Phone**	**Address**	**Email**
Surgeon				
Rheumatologist				
Dermatologist				
Social Worker				
Psychologist/ Psychiatrist				
Dietitian				
Other Provider				

Content in the sections below to be shared with the adult healthcare team before completing transition.

CARE PLAN: MEDICAL SUMMARY

*Please provide **a brief summary** of the diagnosis. Additional details on the history of illness can be provided in the History of Complications section.*			
Diagnosis			
Summary of initial presentation and clinical course of diagnosis			
Date of diagnosis (MM/ YYYY) - at minimum, one year of diagnosis			
Disease type (CD, UC, or IBD-U)			
	☐ Stable/controlled	☐ Unstable/uncontrolled	
Disease activity index			
Disease location			
Phenotype (Paris or Montreal classification)			
Comorbidities related to IBD			
Comorbidities unrelated to IBD			
Allergies to medications			
Other allergies			
	Date (MM/DD/YYYY)	**Date (MM/DD/YYYY)**	**Date (MM/DD/YYYY)**
Weight (kg)			
Height (cm)			
Body mass index (kg/m^2)			
Patient history of growth failure: ☐ None/not applicable ☐ Growth failure history	Details		

CARE PLAN: MEDICATIONS

	Medication 1	**Medication 2**	**Medication 3**	**Medication 4**
Medication name				
Dose				
Start date (MM/DD/YYYY)				
Discontinuation date (MM/DD/YYYY)				
Reason for stop, if applicable (e.g., side effects, complications, compliance, non-adherence)				
Fecal calprotectin (if required)				
ADVANCED THERAPIES	**Medication 1**	**Medication 2**	**Medication 3**	**Medication 4**
Medication name				
Dose and interval (at initial induction)				
Dose and interval (currently)				
Reasons for escalation/de-escalation				
Therapeutic drug monitoring				
Fecal calprotectin (if required)				

CARE PLAN: MEDICATIONS

CORTICOSTEROIDS	Medication 1	Medication 2	Medication 3	Medication 4
Medication name				
Dose and interval (at initial induction)				
Dose and interval (currently)				
Responsiveness				
Total number of courses				
Date of last course (MM/DD/YYYY)				

CARE PLAN: SURGICAL HISTORY

Please include links to surgical and pathology reports

	Surgical Procedure 1	Surgical Procedure 2	Surgical Procedure 3	Surgical Procedure 4
Date (MM/DD/YYYY)				
Name/description				
Reason for surgery				
Post-surgical complication				
Pathology report				

CARE PLAN: IMAGING – ENDOSCOPIES

Please include links to surgical and pathology reports

	At Diagnosis	At Last Endoscopy
Date (MM/DD/YYYY)		
Description		
Disease location		
Severity		
Pathology report		

CARE PLAN: IMAGING – RADIOLOGY

Diagnosis/Initial Visit	Prior to Recent	Most Recent
Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)
☐ Ultrasound result ☐ MRE result ☐ MRP result ☐ CT scan	☐ Ultrasound result ☐ MRE result ☐ MRP result ☐ CT scan	☐ Ultrasound result ☐ MRE result ☐ MRP result ☐ CT scan

CARE PLAN: LABS (PREVIOUS AND NOTEWORTHY INVESTIGATIONS)

Test	Status	Date (MM/DD/YYYY)
IBD-related antibody serology		
Anti-saccharomyces cerevisiae antibodies (ASCA)		
Anti-neutrophil cytoplasm antibodies (ANCA) serology		
Measles, Mumps and Rubella (MMR)		
Thiopurine methyltransferase (TPMT)		
Tuberculosis testing		
Viral Serologies		
Hepatitis A		
Hepatitis B		
Hepatitis C		
Cytomegalovirus (CMV)		
Epstein-Barr Virus (EBV)		
Varicella		
Additional Immunization Details		
Infectious disease history		
Missing immunization (e.g., COVID-19 vaccine)		
Due to be given (e.g., DTaP, pneumococcal)		

CARE PLAN: LABS (RECENT INVESTIGATIONS)

Recent Labs	Results (attach)	Date (MM/DD/YYYY)

CARE PLAN: HISTORY OF COMPLICATIONS

Please elaborate on the brief summary provided in the Medical Summary section and address any complications or additional details.

History of Presenting Illness	
Initial presentation at diagnosis (brief description)	

Hospitalizations: IBD-related Complications		
Description/reason	**Clinical course**	**Date (MM/DD/YYYY)**

CARE PLAN: PSYCHOSOCIAL

When reviewing this section with patient, advise caregiver/parent to step outside of room so you can speak openly with patient.

	Current	Historic
Mental illness, substances abuse, psychosocial risk factors (sexuality/ transgender challenges)		
Smoking status (including vaping)		
Alcohol use		
Living situation, family conflict		
Name of post secondary institution	Address of post secondary institution	

Family history (e.g., IBD, cancer)

Long term life aspiration/goals

Notes or Comments