

TRANSITION READINESS ASSESSMENT FOR GENDER DYSPHORIC/GENDER INCONGRUENT YOUTH

BY THE ENDOCRINE SOCIETY

ENDOCRINETRANSITIONS.ORG

Please fill out this form to help us better understand your knowledge about your health, using health care and areas where we may be able to better support you. If you need help completing this form, please let us know.

Preferred Name: _____ Pronouns: _____

Legal Name: _____ Date of Birth: _____

MY OVERALL HEALTH

PLEASE CHECK THE BOX THAT APPLIES TO YOU RIGHT NOW.	YES, I KNOW THIS	I NEED TO LEARN
My doctors care about me and I feel comfortable asking questions.	<input type="checkbox"/>	<input type="checkbox"/>
My family are supportive of affirming my gender identity.	<input type="checkbox"/>	<input type="checkbox"/>
I am not experiencing any bullying or abuse by others.	<input type="checkbox"/>	<input type="checkbox"/>
I live openly in my affirmed gender without any issues.	<input type="checkbox"/>	<input type="checkbox"/>
I have adequate housing and food.	<input type="checkbox"/>	<input type="checkbox"/>
I have adequate money to support myself.	<input type="checkbox"/>	<input type="checkbox"/>
I can tell other people what my medical needs are.	<input type="checkbox"/>	<input type="checkbox"/>
I am comfortable advocating for myself and my medical care.	<input type="checkbox"/>	<input type="checkbox"/>
I know the medicines I take, and when I need to take them without someone reminding me.	<input type="checkbox"/>	<input type="checkbox"/>
If I have allergies, I know what I am allergic to, including medicines.	<input type="checkbox"/>	<input type="checkbox"/>
I can name 1-2 people who can help with my health goals.	<input type="checkbox"/>	<input type="checkbox"/>

USING HEALTHCARE

PLEASE CHECK THE BOX THAT APPLIES TO YOU RIGHT NOW.	YES, I KNOW THIS	I NEED TO LEARN
I know or I can find my doctor's name and phone number.	<input type="checkbox"/>	<input type="checkbox"/>
I make my own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, I think about questions to ask my doctor.	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, I know to bring in a list of the medications that I am taking.	<input type="checkbox"/>	<input type="checkbox"/>
I know about how to identify potential risks of hormone therapy.	<input type="checkbox"/>	<input type="checkbox"/>
I have a way to get to my doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>
I know how to fill out medical history forms.	<input type="checkbox"/>	<input type="checkbox"/>
I know how to ask to be sent to see another doctor or specialist	<input type="checkbox"/>	<input type="checkbox"/>
I know where my pharmacy is and what to do when I run out of my medicines.	<input type="checkbox"/>	<input type="checkbox"/>
I know where to get a blood test or other tests if the doctor orders them.	<input type="checkbox"/>	<input type="checkbox"/>
I know how to send a message to my healthcare team through the electronic medical system.	<input type="checkbox"/>	<input type="checkbox"/>
I know how to contact my healthcare team after hours when the office is close.	<input type="checkbox"/>	<input type="checkbox"/>

MY EMOTIONAL HEALTH

PLEASE CHECK THE BOX THAT APPLIES TO YOU RIGHT NOW.	YES, I KNOW THIS	I NEED TO LEARN
I know who to contact if I am having poor mood or mood changes.	<input type="checkbox"/>	<input type="checkbox"/>
I know who my support system is who I can turn to if I am facing difficulties.	<input type="checkbox"/>	<input type="checkbox"/>
I know who to contact if someone abuses me or tries to hurt me.	<input type="checkbox"/>	<input type="checkbox"/>