SHARED CARE FOR ALLERGY

Transition from paediatric to adult allergy services

Implementation Guide and Model of Care

ascia australasian society of clinical immunology and allergy

national allergy council

Allergy & Anaphylaxis Australia

Contents

Introduction 3

Who is this implementation guide for? 3

Rationale 3

Paediatric to adult transition of care 4

Why is a good transition process important? 4

Transition and adolescence 4

Who should be transitioned to adult allergy services? 5

Objectives and standards 6

Table 1: Transition of Care Standard for transitioning paediatric adolescents to adult allergy services 7

Implementation Guide 8

Standard 1.1 8

Standard 1.2 9

Standard 1.3 10

Standard 1.4 11

Standard 1.5 12

Standard 1.6 13

Standard 1.7 14

Transition Model of Care 15

Transition phases 15

Planning phase 16

Table 2: Tasks in the transition planning phase 16

Preparation phase 17

Table 3: Tasks in the preparation phase 17

Transfer phase 22

Table 4: Tasks in the transfer phase 22

Evaluation phase 23

Table 5: Tasks in the evaluation phase 23

GP role in transition 24

Paediatric clinician role in transition 24

Adult clinician role in transition 24

Overarching considerations 25

References 28

Resources 30

Appendix 1 - Example of a risk assessment tool 32

Introduction

The National Allergy Council is a partnership between the Australasian Society of Clinical Immunology and Allergy (ASCIA) and Allergy & Anaphylaxis Australia (A&AA) and funded by the Australian Government Department of Health, Disability and Aging. As part of the Shared Care for Allergy project, the National Allergy Council developed a Transition of Care Standard for transitioning paediatric adolescents to adult allergy services, released in August 2024.[1]

This implementation guide supports health services to implement a national standard of care for the effective and safe transitioning of adolescents with allergies from paediatric to adult care. It outlines the processes and best practices to ensure that adolescents receive consistent, high-quality care during this critical transition period.

Who is this implementation guide for?

The Transition of Care Standard is designed for public hospitals and health services, though private health services who wish to implement a transition service, are encouraged to use it. Transition occurs across both paediatric and adult services, and this implementation guide is intended to support healthcare professionals, transition coordinators, executives and administrators in translating the standards into practice. The implementation guide does not intend to provide advice about management of individual allergic conditions in adolescents.

General practitioners (GPs) are the primary healthcare providers for young people and should remain as a consistent point of care throughout the person's life. While paediatric and adult allergy specialists provide expert input when needed, the GP continues to oversee the patient's broader health and coordinates care. In this context, the transition is not a shift to the GP, but rather a discharge from paediatric specialist care while remaining under the ongoing care of the GP.

Adolescents, parents, family and caregivers also play an important role in the transition process. This implementation guide can help them understand what to expect from their health service, their responsibilities and how they should be involved in supporting their successful transition.

Roles and responsibilities in transition are further outlined from Page 24 onwards.

Rationale

The rationale for developing the Transition of Care Standard and implementation guide is to ensure:

1. **Safe, continuous care.** People are at higher risk of harm during transitions of care[2]. Young adults (between 10-35 years of age) with a food allergy are at increased risk of fatal anaphylaxis compared to all other age groups.[3] The Transition of care Standard and implementation guide aim to establish a clear transition framework for healthcare professionals, ensuring there are no gaps or disruptions in the continuity of care during the transition from adult to paediatric services.

2. **Best-practice person centred care.** The Transition of Care Standard and the implementation guide are based on evidence and best practice and will optimise outcomes for adolescents and young adults in Australia. Health services can avoid duplication of effort by adopting nationally consistent implementation tools.

Paediatric to adult transition of care

The transition marks a shift in the healthcare management of adolescents from the paediatric setting, where specialised care for children and adolescents is provided, to the adult healthcare system, which caters to a more diverse age range and often involves different protocols, providers and settings.

As adolescents transition to adult allergy services, it's important to recognise the shift in care approach. Paediatric services typically use a family-centred care model, where parents or carers are closely involved in decision-making. In contrast, adult services adopt a patient-centred model, which places greater emphasis on the young person's autonomy and responsibility for their own care.[5]

The transition process requires a comprehensive, integrated and tailored approach to address the unique needs and challenges that may arise for adolescents and young adults to manage their allergies. It involves preparing and equipping individuals, families and healthcare providers to navigate this change effectively, whilst ensuring continuity of care and optimising outcomes.[6,7]

Why is a good transition process important?

Health system data, literature and Royal Commission findings indicate people are at higher risk of harm during transitions of care.[2] Effective communication between paediatric and adult services can often be lacking. Gaps in information transfer can lead to misunderstandings, duplication, or errors in the management of allergy care for the patient. Poorly defined responsibility and accountability of the healthcare team and the adolescent during transition also impact a patient's care.[2]

The goal of transition is to support the adolescent's overall health and help them reach their full potential. By preparing early and thoughtfully for the move to adult services, young people are more likely to engage successfully with the care system and receive the comprehensive support they need to manage complex health needs.[8] For adolescents, a successful transition process also fosters independence and self-advocacy, empowering the person to take an active role in their healthcare journey going into adulthood. Adolescents are also more likely to adhere to treatment plans and attend appointments in adult healthcare services when they have a strong understanding of their condition and the rationale behind their treatment.[7] Building this knowledge and confidence during the transition can help lay the foundation for long-term health management and engagement in adult services.

Transition and adolescence

Adolescence is a critical period marked by significant physical, cognitive and emotional changes, making chronic conditions particularly impactful. Many health professionals report that managing the complexity of health concerns in adolescence, including chronic disease, is more challenging than in other age groups.[9] Individuals living with an allergy (including severe eczema and allergic rhinitis), can experience isolation, depression, anxiety, academic challenges and limitations in leisure activities due to their condition.[7,10-13] A large study of 15 year olds found that those with food allergies had significantly higher rates of depression, bipolar, panic disorder and social phobia than those with no food allergy.[14] Young adults with a food allergy are at increased risk of fatal anaphylaxis[3], making it even more important that they are adequately cared for during this stage of their life.

Key characteristics of adolescence include:

Decision-making is influenced by attitudes and risk-taking behaviour

Adolescents can be more inclined to take risks with allergen exposures (particularly in relation to food allergy) and underestimate the severity of their condition.[7] This can lead to reluctance to adhere to prescribed management plans, not carrying adrenaline devices, not taking necessary medication, not avoiding their allergy triggers, and not letting people around them know about their allergies. Understanding and addressing these attitudes is crucial in tailoring effective allergy care. Strategies are required to acknowledge and navigate their evolving sense of independence and responsibility.[15]

Increased independence and responsibility

As adolescents transition from paediatric to adult services, they often face increased independence and responsibility for their own health. This shift encompasses emotional and psychological adjustments. Navigating these changes requires a supportive and knowledgeable healthcare approach that recognises and addresses the evolving needs of adolescents.[7,16]

Development of self-management and self-advocacy skills

Adolescents need a specific approach for them to obtain a comprehensive understanding of the health system and self-advocacy skills.[7] It is important for them to learn the knowledge and confidence to become competent adult patients.[7] Adolescents will need to obtain their own Medicare card, be aware of their eligibility for government support programs (such as Centrelink, National Disability Insurance Scheme, Healthcare concession cards), consider ambulance cover, private health insurance, and understand the cost of medications and private appointments.

Significant life changes

The transition from paediatric to adult allergy services often occurs at a time where there are other significant changes happening in an adolescent's life, which can impact their psychosocial wellbeing.[7] Leaving school often coincides with paediatric to adult health services transition, which can mean going into paid employment or further study.[17] These changes can impact an adolescent's social and support networks and their ability to adjust to new responsibilities in managing their health. For adolescents living with allergies who move out home, it means they need to take on the responsibility of buying their own food and, informing housemates of their allergies whilst losing any support their parents were previously providing in their home.[18]

While transitioning health care services may provide an opportunity for young adults to become more independent and responsible, it could lead to lapses in optimal healthcare management for those who are not ready or adequately prepared to assume responsibility.[19] Young adults aged 18-25 years can disengage from healthcare due to several contributing factors including:

- Completion of university studies and now working full time/inflexible hours.
- Moving out of their family home, which may result in a loss of their support network that was previously readily available. They may also lose their private healthcare coverage when they move out of home if they were covered under a family policy.
- Financial constraints which may become overwhelming for people who are just getting started in their career or are navigating financial independence. Limited access to affordable specialty care, medications, and allergen-free foods can have an impact.[20]
- Exploration and experimentation including engaging with alcohol and/or drugs or other risk-taking behaviours.[21]
- New experiences such as attending music festivals and travelling.
- Not wanting to engage until they are in a 'crisis'.[22]

The transition to adult allergy services should be a thoughtful and personalised process, avoiding periods of significant life changes or stress. This means it should not take place during times of heightened pressure, such as the adolescent's final year of school, a move to a new home, or other major life transitions if it can be avoided.

Who should be transitioned to adult allergy services?

Not every adolescent will require a formal transition to adult allergy specialist services. Care needs may vary significantly based on the severity, complexity and ongoing management requirements of each individual. Many adolescents can continue to be appropriately and safely managed by their GP, who remains the primary medical professional involved in their care throughout childhood and into adulthood.

In these cases, the adolescent is not "transitioning to the GP," but rather being discharged from specialist allergy care while continuing under the care of their GP. The decision about whether an adolescent requires transition to adult allergy specialist services should be made by the paediatric health care team. See **Appendix 1** for example model of assessment risk tool that can be used to determine which adolescents may require transition to an adult allergy specialist.

The GP plays a central role in coordinating overall healthcare, including allergy management, and should be involved at every stage of the child's life - not just when specialist care is no longer required. It is important that the adolescent is encouraged to have their own GP, if they do not already do so. Effective communication between the specialist team, the GP, and the adolescent is essential when discharging from specialist allergy services. This ensures the GP is fully informed about the adolescent's allergy history, current management needs, and the circumstances under which re-referral to an adult allergy specialist would be appropriate should their condition change.

Objectives and standards

The objectives of the transition of care process for people with allergies are:

- To enable a safe and coordinated transfer of care of adolescents from paediatric to adult allergy services.
- To empower the adolescent to self-manage their allergy and healthcare requirements as able.

The transition implementation guide is underpinned by the National Allergy Council's Transition of Care Standard that was developed in June 2024 **(Table 1)**[1]. The Transition of Care Standard of care is applicable to patients in a public hospital; however, the implementation guide can be a resource for any service (public or private) who are developing a transition service.

Table 1:

Transition of Care Standard for transitioning paediatric adolescents to adult allergy services

Quality statement
There will be effective transition of patients' care from paediatric to adult allergy healthcare services, ensuring continuity, safety, quality and effectiveness in care delivery, with the adolescent being central to the process.
Intent of the Statement
The development of this standard is to guide the transition of care for adolescents with allergies in Australia from paediatric to adult services.
Patient/carer outcome
I can expect my allergy health care providers to work with and help me transition from paediatric to adult services to maintain access to the provision of safe, high-quality and comprehensive allergy care.

Standard 1.1	Services will develop and utilise clear criteria and methods for assessing transition readiness and prioritisation, with consideration of the adolescent's medical history, health status, severity, co-morbidities, and psychosocial factors. Where possible, services should align the timing and frequency of adolescent appointments with the transition process.
Standard 1.2	Services will establish clear referral pathways which enable the adolescent to identify suitable adult clinicians and healthcare teams and understand when and how to access them. Ongoing communication with the adolescent's GP prior to transition is important to ensure that adolescents who are no longer accessing a paediatric allergy service continue care in an adult setting.
Standard 1.3	Services will identify and inform the adolescent of channels and methods of communication between teams, specifying responsible parties and critical information to be shared along with communication frequency.
Standard 1.4	Services will ensure accurate, confidential and comprehensive documentation, including patient information such as medical history, medications, treatment plans, and preferences is provided to the adolescent and to the receiving healthcare team, including their general practitioner.
Standard 1.5	Services will work in partnership with the adolescent to coordinate the adolescent's care during transition and assign responsibilities and tasks to appropriate staff or individuals themselves. There will be clear guidance about which service has clinical accountability, at which point in the process.
Standard 1.6	Services will commence transfer of care planning with sufficient time and provide the adolescent with a timeline for the transition process and task completion, including escalation pathways should timelines or clinical condition change.
Standard 1.7	Services will review processes about their transition processes from feedback and evaluation received from the adolescent patients' experiences to ensure ongoing improvement and adherence to protocols.
Standard 1.8	Services will use the transfer process as a cue to promote optimal self-management of the adolescent in their allergic condition.

Implementation Guide

Standard 1.1

Services will develop and utilise clear criteria and methods for assessing transition readiness and prioritisation, with consideration of the adolescent's medical history, health status, severity, co-morbidities, and psychosocial factors. Where possible, services should align the timing and frequency of adolescent appointments with the transition process.

A well-timed and carefully planned transition from paediatric to adult allergy care helps ensure continuity, reduces the risk of disengagement, and supports young people to feel confident and prepared. Assessing whether an adolescent is ready to begin the transition requires a holistic view of their medical and psychosocial context, not just their age. This includes understanding their allergy management needs, broader health status, and ability to engage in decision-making about their care. Establishing standardised criteria for assessing readiness helps to ensure fairness, consistency, and a patient-centred approach across the health service. At present, there is no national or international standardised criteria that determines which adolescents should be transitioned to adult allergy services. This means it is up to individual healthcare providers or services to establish their own criteria based on clinical judgment and patient-specific factors and risks.

Translating the Standard into practice

Services should:

- Develop a co-design process involving patients, their families, paediatric and adult clinicians, and primary care providers.
- Establish clear and standardised readiness assessment tools or checklists that include:
  - medical history
  - current health status
  - severity
  - co-morbidities
  - psychosocial factors
  - health literacy of adolescent and/or carer
  - cognitive and emotional development
  - incorporate a readiness assessment into routine paediatric appointments.
  - align appointment schedules with the transition process and increase the adolescents' involvement during appointments.

See **Appendix 1** for example model of assessment risk tool that can be used to determine which adolescents may require transition to an adult allergy specialist.

Standard 1.2

Services will establish clear referral pathways which enable the adolescent to identify suitable adult clinicians and healthcare teams and understand when and how to access them. Ongoing communication with the adolescent's GP prior to transition is important to ensure that adolescents who are no longer accessing a paediatric allergy service continue care in an adult setting.

To support a smooth and effective transition from paediatric to adult allergy care, services must ensure that adolescents and their families have access to clear and consistent referral pathways. These pathways should help identify appropriate adult clinicians or healthcare teams and understand how and when to access them. The adult allergy service should define the referral criteria, referral procedures and required documentation. The paediatric allergy service should initiate the referral process, assess whether the adolescent meets the referral criteria, and ensure the appropriate information is included in the referral. They should also educate the adolescent and their family about the transition pathway.

Translating the Standard into practice

A clear referral pathway should include:

- Defined referral criteria
- Identification of suitable adult clinicians and/or adult healthcare teams
- Timeframes for referral
- Information to be included in the referral
- A process to confirm acceptance by the receiving service
- How to identify a transition coordinator/facilitator (if there is one available)
- Involvement of the GP in the referral pathway
- The setup or use of joint clinics (if there are clinics available)

For adolescents who are transitioned to a GP instead of an adult allergy specialist, it is critical that key factors or clinical presentations are discussed that may warrant re-referral to specialised care. These may include:

- New or worsening allergic reactions (e.g., anaphylaxis)
- Increased frequency or severity of symptoms (e.g., several exposures to known food allergens, poorly controlled asthma, eczema flare-ups)
- Allergies to new or additional triggers that were not previously identified
- Concerns about the efficacy of current treatments (e.g., poor response to medications, side effects)
- The need for specialised interventions, such as oral food challenges or medication challenges

The adolescent's GP should be provided with clear guidelines on when a referral or re-referral to adult allergy services might be necessary. This ensures that any significant changes in the patient's condition are addressed promptly, preventing gaps in care and maintaining optimal allergy management as the patient transitions into adulthood.

Standard 1.3

Services will identify and inform the adolescent of channels and methods of communication between teams, specifying responsible parties and critical information to be shared along with communication frequency.

To ensure the effective and efficient transfer of information during the transition from paediatric to adult allergy services, it is essential that clear channels and methods of communication are established between everyone involved, including the adolescent, their family, GPs, paediatric healthcare teams, and adult healthcare providers.

Translating the Standard into practice

The following actions should be taken and documented:

- Confirm channels and methods of communication between paediatric, GP and adult healthcare teams (e.g. electronic health record systems, referral letters, secure email etc)
- Confirm and agree on communication methods with the adolescent and their family (e.g. phone calls or text, written summaries, email etc)
- Clearly identify who is responsible for sending, receiving and following up on key transition information. Each person's role in the communication process should be explicitly outlined.
- Frequency and timing of communication

Standard 1.4

Services will ensure accurate, confidential and comprehensive documentation, including patient information such as medical history, medications, treatment plans, and preferences is provided to the adolescent and to the receiving healthcare team, including their general practitioner.

Accurate and comprehensive documentation is essential to support a safe and effective transition from paediatric to adult allergy services. Ensuring that key health information is clearly recorded and shared with the adolescent, their family, the receiving adult healthcare provider, and their GP helps to maintain continuity of care and avoid critical gaps in management. This documentation should reflect not only clinical details such as medical history, medications, and treatment plans, but also the adolescent's preferences, goals, and any special considerations they have communicated during their care.

Translating the Standard into practice

The following considerations can help services ensure that documentation is accurate, complete, and appropriately shared with all relevant parties during the transition process.

- Ensure patient information is recorded accurately, confidentially and comprehensively
- Include important details such as:
  - medical history
  - medications
  - treatment plans
  - special considerations or support needs
  - information disclosed by the adolescent including preferences, goals or values
- Ensure that confidentiality is upheld, with sensitive information shared only with appropriate providers using secure methods
- Ensure all team members understand their responsibilities in handling the documentation under privacy legislation
- Ensure documentation is accessible to the adolescent (and family, where appropriate) in a format they can understand and refer back to
- Use standardised templates or checklists, where available, to support consistency and completeness
- Ensure all relevant health care providers have access to relevant documentation
- Ensure efficient and secure information portals are used e.g. MyHealth Record

Standard 1.5

Services will work in partnership with the adolescent to coordinate the adolescent's care during transition and assign responsibilities and tasks to appropriate staff or individuals themselves. There will be clear guidance about which service has clinical accountability, at which point in the process.

Coordinating care during the transition process is essential to ensure adolescents feel supported and remain actively engaged in their healthcare. This involves working in partnership with the adolescent to support them to take increasing ownership of their care, assigning clear roles and responsibilities to healthcare providers, and outlining who is accountable at each stage of the transition.

Translating the Standard into practice

The following actions can help services effectively coordinate care and define responsibilities throughout the transition process:

- Define how the coordination of care will be managed during the transition process, including identifying a lead clinician or transition coordinator (if available)
- Assign clear responsibilities for specific people and tasks, ensuring everyone involved understands their tasks and accountability (including the adolescent)
- Involve the adolescent in planning and decision making including setting goals and discussing preferences in care
- Encourage the adolescent's gradual independence while providing appropriate support.
- Develop a timeline of transition and when each specific task should be completed
- Ensure flexibility to allow adjustments based on the adolescent's readiness, health needs or personal change in circumstances
- Develop and monitor follow up mechanisms and processes with clear guidelines on frequency, particularly in the initial stages, to address emerging issues promptly

Standard 1.6

Services will commence transfer of care planning with sufficient time and provide the adolescent with a timeline for the transition process and task completion, including escalation pathways should timelines or clinical condition change.

A well-planned transition requires sufficient time for preparation and coordination to ensure a smooth transfer of care. Services should begin transition discussions early, ideally well before the actual transfer, to allow the adolescent and their family to understand the process, set expectations, and complete necessary tasks. Providing a clear timeline helps adolescents prepare for their new healthcare setting, reduces anxiety, and ensures critical steps are not missed. If clinical conditions change or delays occur, escalation pathways should be in place to address these issues promptly.

Translating the Standard into practice

To ensure successful and timely transfer of care, services can take the following actions:

- Begin transition planning early so there is enough time to build the adolescents understanding, skills and confidence before the transfer
- Develop and share a written timeline with the adolescents (and family where appropriate), outlining key milestone, responsbilities and dates
- Review and update the timeline as required
- Ensure all services are aligned to the same timeline

Standard 1.6 is closely linked to the first three phases (planning, preparation, transfer) of the transition phases outlined in **Figure 1 – Transition phases**. These phases are critical for setting expectations, outlining responsibilities, and ensuring a structured, timely handover of care. By providing adolescents with a clear timeline, identifying key tasks, and including escalation pathways, services can support a smoother, more coordinated transition that adapts to the adolescent's changing needs.

Standard 1.7

Services will review processes about their transition processes from feedback and evaluation received from the adolescent patients' experiences to ensure ongoing improvement and adherence to protocols.

Listening to the voices of adolescents and their families helps services understand what aspects of transition are working well and where improvements are needed.

Translating the Standard into practice

Services can:

- Collect feedback to evaluate the transition process
- Involve adolescents and families in the co-design of service improvements, promoting a culture of shared learning and collaboration

Ongoing evaluation of the transition process is essential to ensure it remains effective, person-centred, and aligned with best practice. Standard 1.7 is linked to the fourth phase (evaluation) of the transition process in **Figure 1 - Transition phases.**

Transition Model of Care

Transition phases

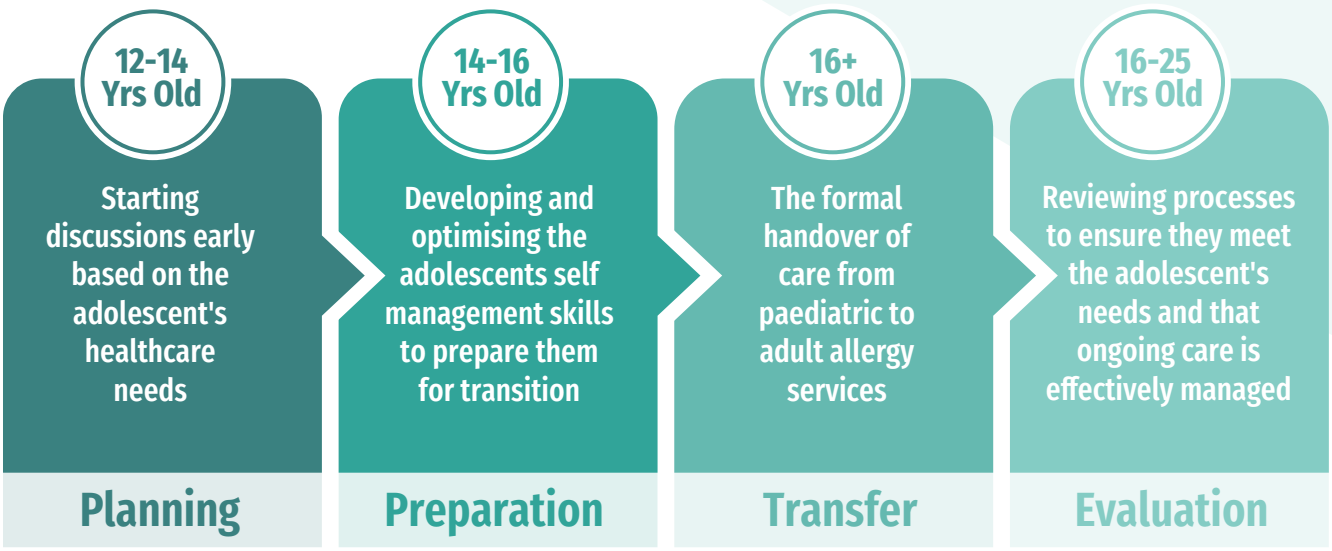
Implementing a structured transition service involves recognising that transition is a process, not a single event. The transition process consists of several key phases designed to guide adolescents smoothly from paediatric to adult allergy services. Each phase plays a crucial role in ensuring the adolescent is prepared, supported, and equipped to manage their condition in an adult healthcare setting. A structured approach helps to minimise gaps in care, clarify responsibilities, and provide a clear pathway for both the adolescent and healthcare providers.

By following these phases, healthcare services can implement a structured transition service within their organisation.

There are four phases of transition: planning, preparation, transfer and evaluation.[23]

Figure 1:

Transition phases (ages are approximate)



Planning Phase

The planning phase can commence as early as 12 years old but usually around the age of 14 years, depending on appointment schedule, or when developmentally appropriate for the adolescent. Timing for the initiation of the transition process should be guided by the adolescent's readiness, rather than their chronological age.[7]

This involves introducing the adolescent and their family to the concept and importance of transitioning their care.

Table 2:

Tasks in the transition planning phase

Transition Task	Process	Responsibility
Identify young patients who will need to transition to adult services in the next 2-4 years.	• Early identification, assessment, patient and family engagement and coordination with healthcare teams to determine who will need to transition to adult allergy services.	Paediatric healthcare services
Introduce the concept of transition of care in discussions	• Introduce the adolescent and their family or carers to the concept and importance of transitioning care. • Discuss and gauge the adolescent's readiness, willingness and motivation to engage in transition. • Start transition discussions gradually, ideally by the time the adolescent is around the age of 14 years old.[23] • Ensure timelines are flexible and are based on the adolescent's understanding, capabilities, maturity and preparedness. • Encourage adolescents to strengthen their relationship with their own GP in the period leading up to transition.	Paediatric healthcare professional Adolescent, parents, family & caregivers
Ensure primary care involvement	• Include GPs as part of the care team from the first stages of seeing the adolescent. • Send a letter to the GP regarding the adolescent's readiness to transition.	Paediatric healthcare services
Assign a transition coordinator (if available)	• Assign a transition care coordinator (this can be an allergist, nurse, GP, or hospital transition coordinator) to oversee and manage the transition process.	Paediatric healthcare services

Preparation phase

The preparation phase commences at ages 14 to 16 years, or when developmentally appropriate.

This phase involves the adolescent working on developing the skills and knowledge necessary to independently manage their allergy. The focus shifts from relying on parental support to empowering the adolescent and increasing their confidence and capacity for self-management. During this phase, confidentiality, rights and self-advocacy are explored and discussed. It is also important to discuss the value of having a regular GP, as they play a key role in ongoing care.

Table 3:

Tasks in the preparation phase

Transition Task	Process	Responsibility
Conduct a medical review	• Conduct a standard medical review, including seeing the patient alone for part or all of the review. • Identify and manage any key risks. • Anticipate possible changes in the adolescent's condition	Paediatric healthcare services
Assess the readiness of the adolescent to transition.	• Consider the adolescent's medical history, current health status, severity of allergies, co-morbidities, and psychosocial factors.	Paediatric healthcare services
Promote the adolescent's knowledge of disease, decision making and self-management skills.	The transition process should empower adolescents to be more knowledgeable about their condition and to take responsibility for communication and decision-making. This means: This means empowering adolescents to take charge of their own healthcare so that they can take part in decisions about themselves, explain their medical history and concerns clearly and navigate the health system independently. Healthcare providers can talk with the adolescent about: • Independent healthcare behaviours such as → Knowing their medical history → Understanding their allergic condition → Booking and attending appointments → Knowing how communicate with healthcare professionals → Understanding privacy and confidentiality • Risk reduction strategies such as → Having two in date adrenaline devices → Having an accessible ASCIA Anaphylaxis Action Plan and knowing how to use it	Paediatric healthcare services

Transition Task	Process	Responsibility
	• Eating out safely → Telling people about their allergy (friends, work etc.) • How to use their medications • How to access health information • How to ask for support when they need it • Medicare/healthcare card • Private health insurance • Government support programs • Understanding medical letters and prescriptions • Rural and remote considerations • The use of apps (such as the MyTransition app) and portals (such as MyHealth Record) • Who they can contact when they are unwell or have any questions	
Undertake assessments and/ or discussions to understand the psychosocial needs of the adolescent.	Several key areas should be addressed to ensure a holistic and supportive transition: • **School** - leaving school often coincides with transition, impacting social circles and support networks. Healthcare providers should address any concerns and discuss potential adjustments for new educational or workplace settings. • **Finances** – understanding the costs of allergy care (including public vs private) and the financial aspects of the health system. Heath care providers should advise where to find information on Medicare, Centrelink and the National Disability Insurance Scheme (if applicable). Adolescents need to be aware of available resources and how to access support if required. • **Friends and peer support** – losing the peer environment from school can affect mental health. Support groups or counselling may be required to help adolescents cope with these changes. • **Living arrangement**s –changes in living situations may impact healthcare and potential effects should be addressed.	Paediatric healthcare services Psychologist

Transition Task	Process	Responsibility
Develop a personalised transition plan.	An individualised transition plan should be developed in consultation with the adolescent and their family and should be updated as needed. When developing a transition plan, health care professionals should: • Conduct a personalised approach • Ensure the adolescent's preferences are taken into consideration and that they are involved in the decision-making process. • Address concerns and questions of the adolescent by conducting active listening and creating a supportive environment. • Address specific healthcare needs and personal goals and values of each patient. • Make the plan available in an 'easy read' plain English format. • Provide a copy to the adolescent, family/carer and GP.	Paediatric healthcare services Adolescent, parents, family & caregivers Transition coordinator
Provide the adolescent with their healthcare information	• Adolescents should be provided with information including a summary of their allergy history, ongoing medical needs, including medications, and specialist referrals, along with their transition plan. • A copy of this information should also be sent to their GP.	Paediatric healthcare services Nurse practitioner/ allergy educator Transition coordinator
Provide transition education and/or information	Ensuring adolescents are empowered with knowledge and are fully engaged during the transition process helps them actively participate and make informed decisions about their allergy care. Healthcare providers should provide: • Educational content tailored to the needs and circumstances of adolescents and families. • Easily accessible resources in different formats and catering for different levels of health literacy. • A reliable point of contact for questions or concerns. • Transition specific information that addresses specific challenges and considerations. • Education that is culturally sensitive • Information to adolescents regarding additional support services available including advocacy groups, counselling services and other resources (such as Allergy & Anaphylaxis Australia, Allergy 205K).	Paediatric healthcare services Nurse practitioner/ allergy educator Transition coordinator

Transition Task	Process	Responsibility
	It is important that healthcare providers: • Include the adolescent and their carer/families in education. • Ensure the adolescent is aware of what the shift in responsibility from parent/carer to adolescent means. • Encourage self-advocacy by empowering adolescents to take an active role in their healthcare decision making and self-management. • Provide sufficient information and resources to adolescents who express reluctance to attend follow up appointments after their initial appointment.	
Involve the adolescent's entire healthcare team in the transition process	The multidisciplinary approach fosters collaborative efforts among healthcare professionals to address the multifaceted needs of adolescents and ensuring a well-coordinated transition experience. This requires: • Comprehensive involvement of the entire healthcare team. • A coordinated approach in addressing the medical, emotional and social needs of the adolescent. • Effective communication and collaboration between team members to facilitate relationships and the exchange of information. • Clear roles and responsibilities defined in a transition protocol so that each healthcare team member understands their specific contribution to the transition process. The multidisciplinary team should include: • Paediatrician • Adult clinician (if applicable) • GP The multidisciplinary team may also include: • Psychologist, dietitian, social worker, other allied health • Aboriginal Health practitioner • Nurse/nurse practitioner • Transition coordinator • Other specialists This requires effective communication between all healthcare team members during the transition process.	Paediatric healthcare services Adult healthcare services GP Transition coordinator Any other relevant healthcare providers

Transition Task	Process	Responsibility
Identify adult healthcare services/ providers	• Evaluate accessibility, location and availability of potential adult allergy services. • Ensure potential adult services have the capacity to provide care. • Engage the adolescent during this process by discussing preferences, specific healthcare needs and access. • Ensure referral criteria (e.g. who is or is not accepted for referrals) and capacity is communicated to paediatric services.	Paediatric healthcare services Adult healthcare services Adolescent, parents, family & caregivers
Identify if other support services are required	• Identify if other support services are required, for example culturally and linguistically diverse, out-of-home care or mental health, and connect the adolescent to the available services. • If applicable, identify Aboriginal health staff who can support and provide clinical care to Aboriginal young people and families.	Paediatric healthcare services Adolescent, parents, family & caregivers
Utilise referral pathways	• If referring to an adult allergy service, provide a detailed referral to the adult clinician that covers key information. • The referral process may need to begin one to two years before the adolescent's first appointment with a new adult clinician (or other health professional they are being transitioned to). This will allow time for the referral to be received, triaged and entered and for the adolescent to have an initial appointment with the adult clinician.	Paediatric healthcare services
Share medical records and other important health information	Adult clinicians and GPs may not have access to test results and documents outside of local health districts, specialty health networks, or private practices. • Ensure consent processes are followed for the release and exchange of information. • Send relevant medical and personal information with the referral information, confidentially, to the receiving adult healthcare team. • Include the adult clinician and GP in any further correspondence with results after the initial referral.	Paediatric healthcare services

Transfer phase

The transfer can commence at the age 16 years or over, or when developmentally appropriate.

This phase involves the actual transition of care from paediatric to adult setting. It occurs when the adolescent is ready to assume responsibility for their healthcare in an adult clinic. The timing should be dictated by when the adolescent finishes school as transfer should not happen during times stress for adolescent to ensure a smooth and manageable transition.

Table 4:

Tasks in the preparation phase

Transition Task	Process	Responsibility
Confirm receipt and acceptance of referrals from paediatric clinicians	• Send documentation to the paediatric healthcare service to acknowledge and communicate receipt and acceptance (or refusal) of the adolescent as a patient.	Paediatric healthcare services
Consider holding a case conference or joint initial appointment to facilitate the transition to the adult clinician	• Reach out to the adult clinicians to invite a case conference or joint initial appointment to discuss the adolescent's medical history, treatment plan, or any special considerations. • Invite the GP to case conference.	Paediatric healthcare services Transition coordinator GP
	• Reach out to paediatric colleagues to discuss holding a case conference or joint initial appointment to discuss the adolescent's medical history, treatment plan, or any special considerations. • Invite the GP to case conference.	Paediatric healthcare services Transition coordinator GP
Update the transition plan as required.	• Monitor the adolescents progress, their healthcare needs and any new concerns or life events. • Use any information provided by the adolescent or their family/caregiver to adjust the transition plan as required to ensure its relevancy and effectiveness.	Paediatric healthcare services Adult healthcare services Transition coordinator
Hold first appointment with adult team.	The adolescent will attend their first appointment with an adult clinician with/without their parent and/or caregiver.	Adult healthcare services Adolescent, parents, family & caregivers

Evaluation phase

The evaluation phase commences after transition has occurred which could be from the ages of 16-25, depending on the individual adolescent. This is the final stage of the transition process.

Table 5:

Tasks in the preparation phase

Transition Task	Process	Responsibility
Evaluate the transition process	Healthcare providers should integrate measurable indicators to systematically evaluate and enhance the effectiveness of the transition process. Healthcare providers should: • Undergo regular reviews of their transition process, provide ongoing education for staff and adopt the latest research, evidence and best practices in transition. • Implement mechanisms to obtain feedback from the adolescent, carer and healthcare professionals involved in the transition. • Review and refine transition protocols based on feedback. Feedback mechanisms to capture the adolescents experience and feedback that should be considered include: • Patient reported outcome measures (PROMs), or Patient reported experience measures (PREMs). • Surveys. • One on one discussions.	Paediatric healthcare services Adult healthcare services
Follow up with the adolescent	• Conduct a follow up with the adolescent in the first-year post transition. This can be via a phone call, SMS or survey to determine if the adolescent has successfully engaged with a GP and/or adult health services.	Paediatric healthcare services Nurse practitioner/ allergy educator Transition coordinator

The following information is adapted from the Agency for Clinical Innovation (ACI) guidance on roles in transition, which outlines the responsibilities of health professionals and services in supporting adolescents as they move from paediatric to adult care.[24]

GP role in transition

A GP has an important role in the transition of the adolescent and preparing their family and carers, whether the adolescent is transitioned to an adult specialist or if they are transferred back to the GP. It is important the adolescent has a regular GP who they see and trust (or alternatively a GP within the same practice). A consistent GP presence helps ensure continuity of care and reduces the risk of the young person falling through the cracks during what can be a vulnerable period. The GP should cover these areas:

- Encourage young people to begin attending their appointments independently when appropriate to do so.
- Ask young people who they would like to have involved in their healthcare decision making, depending on the young person's capacity.
- Explore other health and social needs and goals, for example relationships, sexuality, study and work needs.
- Be involved as part of the care team from the time of diagnosis.
- Ask young people about their transition plans, especially from the age of 14.
- Request appropriate documentation from specialists if it is not already received.
- Be invited to participate in case conferences and transition planning.
- Offer a GP Management Plan to enable longer appointments and provide care coordination.
- Consider recommending more regular appointments around the time of transition and follow up after appointments, especially with new specialist teams.

Paediatric clinician role in transition

- Identify the adolescents who will transition to adult allergy services.
- Encourage the adolescent to find their own GP, and/or strengthen their relationship with their GP
- Where appropriate, identify Aboriginal Health staff, or other applicable support services who can support the adolescent during the transition period.
- Support the adolescent to be involved in their own health care.
- Help the adolescent and their family understand their changing roles and responsibilities as the adolescent moves to adult allergy health care services.
- Encourage the adolescent to discuss who they would like to involve in healthcare decisions and how they would like them to be involved.
- Include GPs as part of the care team and the transition planning as soon as possible.
- Ensure referrals are made well before the last planned appointment.
- Consider holding a case conference or joint initial appointment to facilitate the transition to the adult clinician. Reach out to the adult clinician to offer this opportunity. Invite the GP to case conferences.
- Send all relevant documentation with the referral and include the adult clinicians in any correspondence and results after the initial referral is made.

Adult clinician role in transition

- Consider setting clinic time aside specifically for adolescent and young adult patients and consider longer appointments initially.
- Empower young people to be a part of the conversation and encourage questions. Allow for opportunities to include family members, carers and other support people.

- Encourage and respect emerging independence and identity.
- Build rapport so the young person is comfortable to ask questions around lifestyle, i.e. sex, drugs and alcohol and impacts of their condition and treatment.
- Consider their needs for education and vocational support.
- Learn about the young person's other support networks.

Assist the GP, coordinator or facilitator and other clinicians:

- Strengthen linkages with their GP or Aboriginal Medical Service.
- Ensure documentation is provided to the GP.
- Ensure GPs are given information about rarer conditions and treatments, including medications.
- Work with the local transition coordinator or facilitator if available.
- Work with other providers, such as community therapists, psychologists, other medical specialists, and include them in your correspondence with the young person's consent.

Overarching considerations

There are overarching considerations to the transition model which must be considered throughout each phase. These include:

Health literacy

Adolescents and families with poor health literacy may have difficulty understanding the transition process and may require extra support to ensure they understand and are able to make informed decisions about their care. Various forms of communication and/or resources must be considered.

Connectivity and technology

Some adolescents and families may not have reliable access to devices or systems that are needed for telehealth and digital communication. It's important to assess this early, ideally at the first point of contact, to determine how they can be appropriately supported.

Privacy

It is important to maintain an adolescent's privacy throughout the transition process. This fosters trust between the young person and their healthcare providers, encouraging open communication and active participation in their own care.

Supported transition for all abilities

Adolescents with an intellectual and/or other disability may require additional time and support during the transition process. It is essential to assess each individual's cognitive ability, communication needs, and level of independence when planning the transition. Services may need to engage earlier with the adolescent, their family or carer, and relevant support networks (such as disability services or school-based teams). Coordination between healthcare, disability, and community services is also important. Transition planning must also account for supported decision-making and guardianship arrangements where relevant.

Appropriate care for diverse communities and special population groups

Perceptions of allergy care can differ greatly in people from culturally diverse backgrounds, and this can affect their understanding and decisions. Healthcare providers must be culturally sensitive, understanding and respecting the local customs, beliefs, and preferences of individuals and communities during the transition process. A professionally trained interpreter (not a family member or friend) should be made available when communicating with people with limited English proficiency.

Special population groups can include Aboriginal and Torres Strait Islander people, people with disabilities, people experiencing socioeconomic disadvantage, people with chronic mental health or psychiatric concerns and sexually and gender diverse groups.

Healthcare professionals must actively consider access requirements, provide tailored support and must make reasonable adjustments where required.

Early transfer to adult services

In some cases, young people may begin receiving care in adult health services as early as 10-12 years old, or even younger. In these situations, the transition process is more about ensuring that the care delivered within the adult system is developmentally appropriate and responsive to the needs of younger patients.

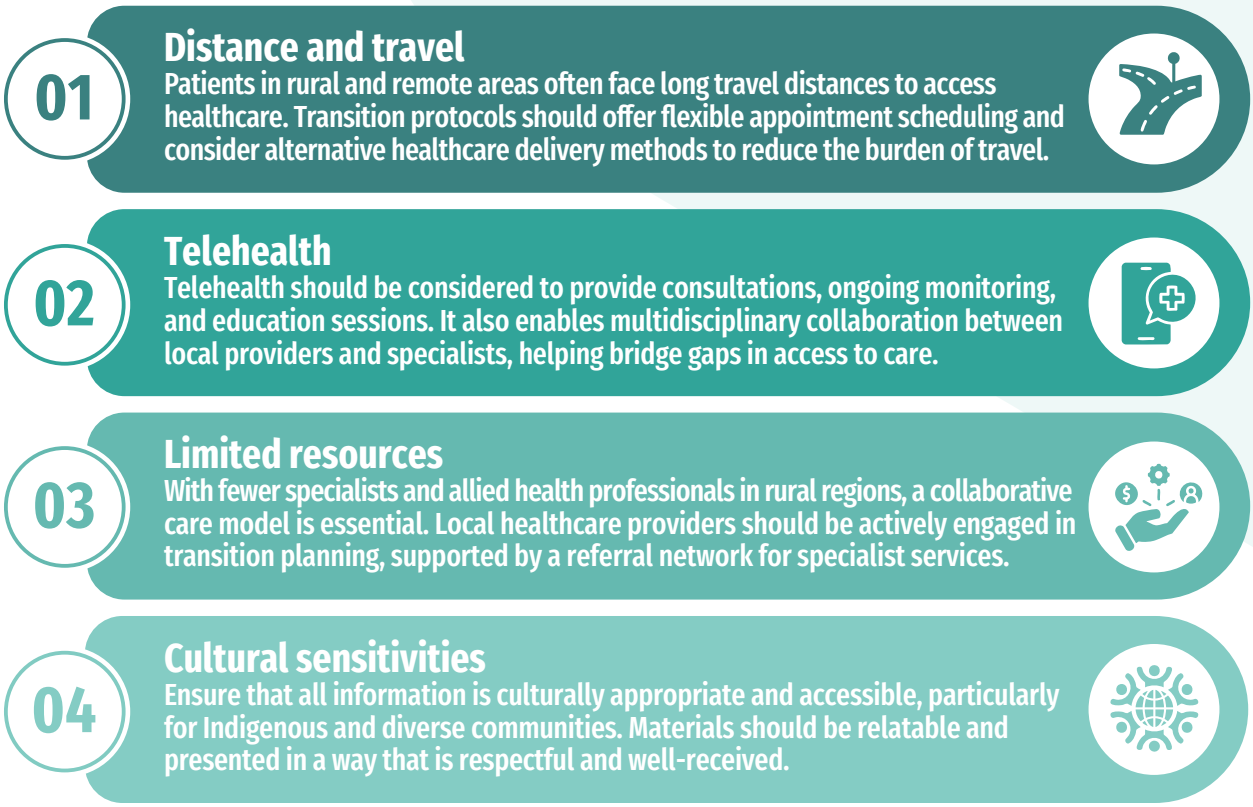
Adult services caring for younger adolescents must adopt key principles of transition within their existing care models. This includes providing additional support to help young people feel comfortable and engaged in their care, using age-appropriate communication strategies, and gradually building health literacy and self-management skills. While the young person may be under the primary care of the adult service, parent or carer involvement should remain central, with clear plans to support increasing independence over time.

Rural and remote

Factors specific to people living in rural and remote areas must be considered including geographic location, distance to services, workforce shortages, limited resourcing and infrastructure. These factors are all potential barriers to receiving equitable care and should be addressed promptly.

Figure 2:

Rural and remote considerations when developing a transition protocol



Encouraging clincians, adolescents and carers to regularly talk about transition and the processes will help build this as part of routine care

Communication

Effective communication is essential through the four transition phases to ensure a smooth transition from paediatric to adult allergy care. Clear, open, and continuous dialogue helps build trust, address concerns, and provide reassurance to both the young person and their family. This ongoing communication sets the foundation for a successful transition, making sure everyone is well-informed and prepared for the changes ahead.

This means:

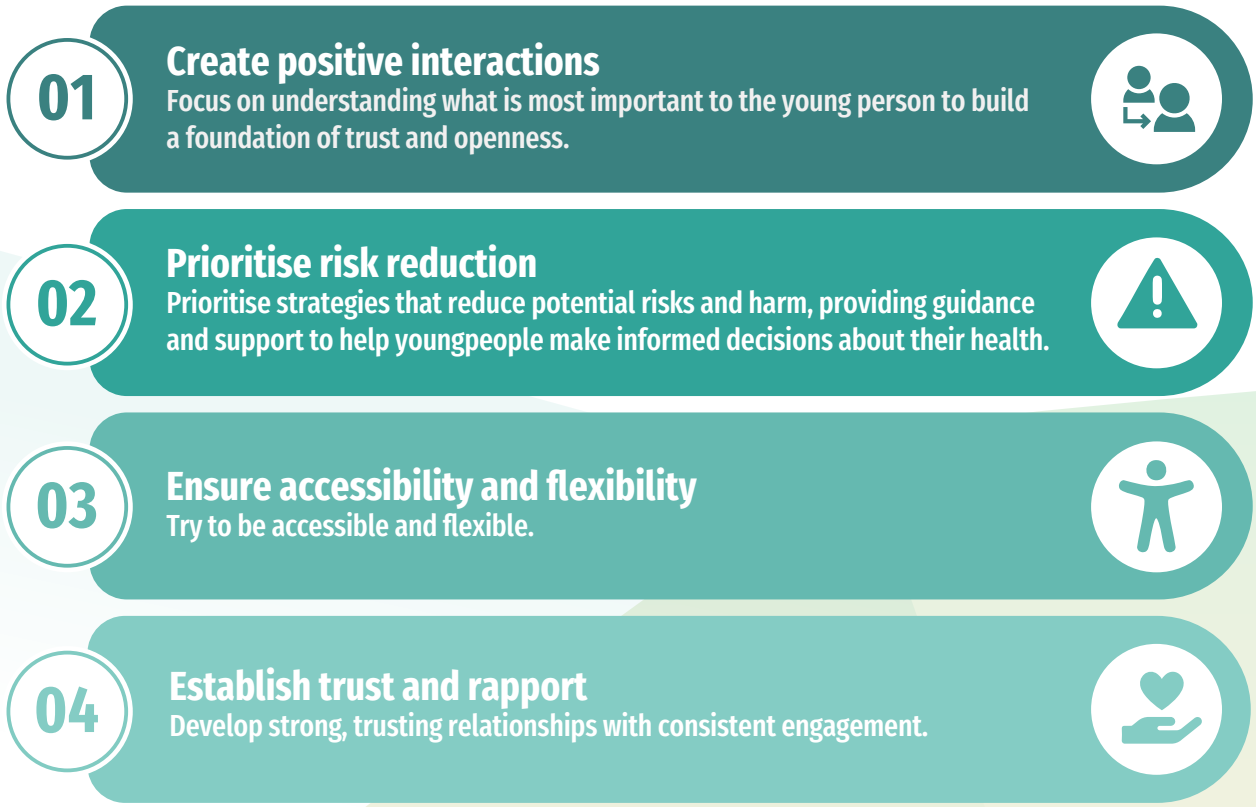
- Clear steps, responsibilities, timelines and communication methods are documented, agreed on and communicated to all involved healthcare providers, the adolescents and/or their families.
- Ensuring there is a process for all involved healthcare providers to share information.
- Fostering a safe environment for open communication and collaboration.
- Actively listening to the adolescent's feedback and individual needs - addressing potential challenges/ barriers as they arise.
- Communicating with consideration to health literacy, language barriers and culture.
- Ensuring continuous communication is conducted through the transition process between both the healthcare providers and the adolescent including conducting regular check-ins, providing opportunities for questions or clarification and providing updates on the progress of the adolescent's transition plan.
- Maintaining regular communication with the GP whilst in paediatric service and involving the GP early in the transition process.
- Recognising the timing and appropriateness of sharing information with adolescents and their families.
- Using technology where appropriate.
- Utilising clear and concise documentation of the adolescent's transition plan and progress.
- Upholding confidentiality throughout the transition process to ensure the privacy and trust of the adolescent and their family. This may involve implementing secure communication channels to safeguard sensitive information.

Navigating the challenges

When supporting young people through the transition from paediatric to adult care, healthcare professionals should focus on how to:

Figure 3:

Key areas for a successful transition



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Resources

Health professionals

Name	Description	Audience	Link
A co-design toolkit	Toolkit	Healthcare professionals	https://aci.health.nsw.gov.au/projects/co-design
Allergy & Anaphylaxis Australia	Website	Adolescents Parents and carers Healthcare professionals	https://allergyfacts.org.au/ https://allergyfacts.org.au/resources/downloads/allergy-guides-for-patients/
ASCIA management summary for allergy conditions	Template	Healthcare professionals	https://www.allergy.org.au/hp/anaphylaxis/ascia-management-summary-allergic-conditions
Checklist for a good referral and handover or discharge letters	Checklist	Healthcare professionals	https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/740383/ACI-Checklist-for-good-referral-handover-discharge-letters.pdf
Got transition	Website with quizzes to help prepare for transition and useful resources for health services.	Adolescents Parents and carers Healthcare professionals	https://www.gottransition.org/
Headspace psychosocial assessment for young people	Assessment tool	Healthcare professionals	https://headspace.org.au/assets/Uploads/headspace-psychosocial-assessment.pdf
HEEADSSS assessment	Clinical tool	Healthcare professionals	headspace Psychosocial Assessment 2013 V2.0
Transition Care Plan template	Template	Healthcare professionals	https://aci.health.nsw.gov.au/__data/assets/word_doc/0019/740206/ACI-Transition-care-plan-template.docx
Transition tips	Fact sheet with practical tips	Healthcare professionals	aci.health.nsw.gov.au/__data/assets/pdf_file/0003/650370/ACI-Transition-tips-checklist-health-professionals.pdf

Adolescents and their families

Name	Description	Audience	Link
Allergy 250k	Website	Adolescents	https://allergy250k.org.au/
Allergy & Anaphylaxis Australia	Website	Adolescents Parents and carers Healthcare professionals	https://allergyfacts.org.au/ https://allergyfacts.org.au/living-with-allergies/understanding-allergy-care/
Anaphylaxis Checklist - Young Adults (Transitioning from Paediatric to Adult Care)	Checklist	Adolescents	https://www.allergy.org.au/patients/allergy-treatments/transitioning-from-paediatric-to-adult-care

Carer gateway	Website with resources	Parents and carers	https://www.carergateway.gov.au/?utm_source=google&utm_medium=paid-search&utm_campaign=10626744435&utm_adgroup=102994881577&utm_term=carer%20gateway&gad_source=1&gclid=EAIaIQobChMI3uCCmYyEhQMVZ6NmAh0a_AI1EAAYASAAEgIU-fD_BwE
Differences in Care	Website	Adolescents	https://nationalallergycouncil.org.au/projects/shared-care-for-allergy/transition
Finding a GP and getting a referral	Website video	Adolescents Parents and carers	https://aci.health.nsw.gov.au/networks/transition-care/resources/finding-a-gp
Getting ready to move to adult health services	Fact sheet	Adolescents	https://aci.health.nsw.gov.au/__data/assets/pdf_file/0006/665700/ACI-Getting-ready-move-transition-factsheet-Easy-read.pdf#:~:text=We%20help%20people%20change%20from%20children%20to%20adult,this%20change%20if%20you%20make%20your%20plan%20early
Got transition	Website with quizzes to help prepare for transition and useful resources for health services.	Adolescents Parents and carers Healthcare professionals	https://www.gottransition.org/
MyTransition app	An online tool to help adolescents feel ready to transition to adult health care system	Adolescents	https://apps.apple.com/ca/app/mytransition-app/id1327036414
Preparing for transition	How to prepare for transition checklist	Adolescents	aci.health.nsw.gov.au/__data/assets/pdf_file/0008/650366/ACI-Preparing-transition-checklist-young-people.pdf
Stages of transition	Fact sheet	Adolescents	https://aci.health.nsw.gov.au/__data/assets/pdf_file/0009/650367/ACI-Stages-transition.pdf
Teenagers with chronic conditions	Information from the Raising Children website.	Parents and carers	https://raisingchildren.net.au/pre-teens/mental-health-physical-health/chronic-conditions/teens-with-chronic-conditions
Three sentence summary	Helps to prepare for health appointments	Adolescents	https://www.cheo.on.ca/en/resources-and-support/resources/Transition-to-Adult-Care/3-Sentence-Summary.pdf
Transition ideas	Ideas for parents and carers to support young people with chronic conditions with their transition	Parents and carers	aci.health.nsw.gov.au/__data/assets/pdf_file/0011/650369/ACI-Transition-ideas-checklist-parents-and-carers.pdf
Transition readiness checklist	Checklist	Adolescents	aci.health.nsw.gov.au/__data/assets/pdf_file/0009/284436/ACI-Transition-readiness-checklist.pdf

Appendix 1 - Example of a risk assessment tool

One way to assess risks is by applying a Flags model[25] (Figure 4). Healthcare professionals can identify risk factors, or "flags," using standardised risk assessment tools or through detailed history-taking.

An example of a Flags model to assess risk factors and transition prioritisation (please note this is an example and is not a validated tool)

Categories	Flag colour	Factors	Transition prioritisation
Biological factors	Red flags	Allergic to one or more staple foods Had anaphylaxis in the last 5 years New allergy diagnoses (within the last 2 years) Have multiple or complex comorbidities	Serious consideration for transition to adult allergy services
Additional factors	Orange flags	Frequent ED presentations relating to allergy History of poor compliance High medication load/complexity Recently started OIT *Have multiple factors across yellow, blue and grey flags	
Mental health factors	Yellow flags	Mental health including anxiety and/or depression	Moderate consideration for transition to adult allergy services (unless adolescent has multiple factors across these flags)
Psychological factors	Blue flags	Display poor coping strategies Lack of engagement Require lots of parental support Have low health literacy	
Social factors	Grey flags	Have low social support From a non-English-speaking background Part of a vulnerable population Planning to move out of home Engage in risk taking behaviours Live in a rural/remote area	

Some factors cannot be changed (e.g. red flags and some grey flags), however a person's perceptions and behaviours may change, and risks could modify between appointments. If an adolescent had no factors identified they would be considered low risk and therefore low consideration to transition to adult allergy services (and may alternatively be transferred to their GP for ongoing management).

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Allergy & Anaphylaxis Australia