



Moving to adult rheumatology: transition checklist

For young people, families, pediatric rheumatology and primary care teams

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Many young people with rheumatic disease are lost to follow-up when they move to adult care, and flares and organ damage can follow. A planned transition, started early, protects against that. The ACR 2026 JIA guidelines strongly recommend assessing transition readiness and making a transition plan.

Skills to build (start around age 12–14)

Knowing my condition

- ☐ I can name my condition and explain it simply
- ☐ I know my medicines, doses and what each one is for
- ☐ I know why I need blood tests and eye checks
- ☐ I can recognize a flare and know who to call

Managing my treatment

- ☐ I take my medicines without reminders
- ☐ I order my own refills
- ☐ I can give an injection myself (if I use one)
- ☐ I know not to stop medicines suddenly without advice

Using health care

- ☐ I can book and keep my own appointments
- ☐ I spend part of each visit with the doctor on my own
- ☐ I know how my health insurance works
- ☐ I carry a medicine list and a short medical summary

Health and life

- ☐ I know how alcohol, smoking and vaping affect my condition and medicines
- ☐ I know which medicines matter for pregnancy and contraception
- ☐ I know about vaccines I need, including yearly influenza
- ☐ I have support for mood, school, work and sport

Steps to transfer

WHEN	STEPS	WHO
Age 12–14	Introduce the idea of transition; start seeing the young person alone for part of the visit; begin a skills checklist.	Pediatric team, family, primary care
Age 14–16	Build self-management skills; agree a target age for transfer; discuss confidentiality and reproductive health.	Pediatric team, young person
Age 16–18	Identify an adult rheumatologist; prepare a written medical summary (diagnosis, key results, treatments tried, current plan, vaccines, eye-screening history); plan a joint or warm-handoff visit.	Pediatric team, adult team, primary care
Transfer	Send the summary and records ahead; confirm the first adult appointment is booked and attended.	Pediatric team, adult team
After transfer	Check the young person is settled with the adult team; follow up any missed appointments.	Primary care, adult team

Primary care can help by

Staying involved through the move (continuity is protective), reinforcing self-management at visits, keeping vaccines up to date, and following up quickly if the young person drops out of rheumatology care.

Sources

1. 2026 JIA guideline summary (PDF).
<https://assets.contentstack.io/v3/assets/bltee37abb6b278ab2c/blt4e307b8933591fa5/jia-guidelines-summary-2026.pdf>
2. Got Transition (national resource). <https://www.gottransition.org/>
3. EULAR/PreS 2017 transitional care standards.
<https://ard.bmj.com/content/76/4/639>