



Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. In the past week, have you been having thoughts about killing yourself? Yes No
4. Have you ever tried to kill yourself? Yes No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? Yes No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - "Yes" to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT safety/full mental health evaluation**.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
 - "No" to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief suicide safety assessment to determine if a full mental health evaluation is needed**. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741



Mental Status Exam

Client Name <i>Demoni</i>		Date <i>2/17</i>	
OBSERVATIONS			
Appearance	<input checked="" type="checkbox"/> Neat	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Inappropriate
	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Other	
Speech	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured
	<input type="checkbox"/> Impoverished	<input type="checkbox"/> Other	
Eye Contact	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Intense	<input type="checkbox"/> Avoidant
	<input type="checkbox"/> Other		
Motor Activity	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Restless	<input type="checkbox"/> Tics
	<input type="checkbox"/> Slowed	<input type="checkbox"/> Other	
Affect	<input checked="" type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input type="checkbox"/> Flat
	<input type="checkbox"/> Labile	<input type="checkbox"/> Other	
Comments: <i>Very energetic</i>			
MOOD			
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Anxious	<input type="checkbox"/> Angry	<input type="checkbox"/> Depressed
<input checked="" type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable	<input type="checkbox"/> Other	
Comments: <i>Very</i>			
COGNITION			
Orientation Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object
	<input type="checkbox"/> Person	<input type="checkbox"/> Time	
Memory Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Short-Term	<input type="checkbox"/> Long-Term
	<input type="checkbox"/> Other		
Attention	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Distracted	<input type="checkbox"/> Other
Comments:			
PERCEPTION			
Hallucinations	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual
	<input type="checkbox"/> Other		
Other	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
THOUGHTS			
Suicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Ideation	<input type="checkbox"/> Plan
	<input type="checkbox"/> Intent	<input type="checkbox"/> Self-Harm	
Homicidality	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Intent
	<input type="checkbox"/> Plan		
Delusions	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Grandiose	<input type="checkbox"/> Paranoid
	<input type="checkbox"/> Religious	<input type="checkbox"/> Other	
Comments:			
BEHAVIOR			
<input type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input checked="" type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated
	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Other	
<input type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Withdrawn
Comments:			
INSIGHT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			
JUDGMENT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			