NIMH TOOLKIT

asQ 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? Tylenol overdose

   When? last Tuesday

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: No

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

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 1 + 6 + 15 =Total Score: 22

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Mental Status Exam

* No longer in school

Client Name	Spencer/Hunch Age 17			**Date** 9-15-25	
OBSERVATIONS	They/She "would like to transition"				
Appearance	■ Neat	□ Disheveled	□ Inappropriate	□ Bizarre	□ Other
Speech	■ Normal	□ Tangential	□ Pressured	□ Impoverished	□ Other
Eye Contact	■ Normal	□ Intense	□ Avoidant	□ Other	
Motor Activity	■ Normal	□ Restless	□ Tics	□ Slowed	□ Other
Affect	● Full	□ Constricted	□ Flat	□ Labile	□ Other
Comments:					
MOOD					
□ Euthymic	● Anxious	□ Angry	□ Depressed	□ Euphoric	■ Irritable □ Other
Comments: Wants to go home					
COGNITION					
Orientation Impairment	□ None	■ Place	■ Object	■ Person	■ Time
Memory Impairment	□ None	■ Short-Term	■ Long-Term	□ Other	
Attention	■ Normal	□ Distracted	□ Other		
Comments:					
PERCEPTION					
Hallucinations	● None	□ Auditory	□ Visual	□ Other	
Other	● None	□ Derealization	□ Depersonalization		
Comments:					
THOUGHTS					
Suicidality	□ None	● Ideation	□ Plan	□ Intent	□ Self-Harm
Homicidality	■ None	□ Aggressive	□ Intent	□ Plan	
Delusions	● None	□ Grandiose	□ Paranoid	□ Religious	□ Other
Comments: Suicide Attempt					
BEHAVIOR					
● Cooperative	□ Guarded	□ Hyperactive	□ Agitated	□ Paranoid	
□ Stereotyped	□ Aggressive	□ Bizarre	□ Withdrawn	□ Other	
Comments:					
INSIGHT	■ Good	□ Fair	□ Poor	Comments:	
JUDGMENT	■ Good	□ Fair	□ Poor	Comments:	

(1) 3rd Visit Here

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
What did you notice during your **mental status examination** of the client? Were there any assessments that were abnormal or that stood out to you? During my mental status exam, I noticed the patient had difficulty maintaining eye contact, their thought process seemed disorganized at times.	If something stood out to you or it was abnormal, explain it's potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so – briefly explain. The disorganized thought process could relate to a psychiatric disorders such as schizophrenia.	What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? What therapeutic communication techniques did you utilize? I asked clarifying questions to gain a better understanding. I maintained a calm + non-judgmental tone + used therapeutic communication.	What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction. I learned the importance of patience and allowing silence during my interview. I will focus more on deeper questions.

Assessment

Noticing	Interpreting	Responding	Reflecting
Why did you choose this **additional assessment**? What did you notice during your **additional assessment** of the client? Were there any assessments that were abnormal or that stood out to you?	If something stood out to you or it was abnormal, explain its potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so – briefly explain.	What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse?	What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction.
I noticed the patient had slow responses + poor eye contact They expressed hopelessness.	These findings suggest depression Symptoms may related to neurotransmitter imbalance and stress	I asked open-ended questions, encouraged them to share feelings, and used silence appropriately.	I learned the importance of patience and active listening I will focus on deep question Next Time.