



Suicide Screening and Risk Assessment

Student Name: _____ DOB: _____ Date of Assessment: _____
 School Name: _____ Grade: _____ Time: _____:_____ am/pm
 Referral Source: _____ Reason for Assessment: _____

RCSS MHT Members Completing Assessment: _____ Name/Title _____ Name/Title _____

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
	YES	NO
Ask questions that are bolded and <u>underlined</u>.		
Ask Questions 1 and 2		
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: <u>Was this within the past three months?</u>		

Low Risk Moderate Risk High Risk

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

RISK ASSESSMENT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.				
Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)	
<input type="checkbox"/>	Actual suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness
<input type="checkbox"/>	Interrupted attempt	<input type="checkbox"/>	<input type="checkbox"/>	Major depressive episode
<input type="checkbox"/>	Aborted or Self-Interrupted attempt	<input type="checkbox"/>	<input type="checkbox"/>	Mixed affective episode (e.g. Bipolar)
<input type="checkbox"/>	Other preparatory acts to kill self	<input type="checkbox"/>	<input type="checkbox"/>	Command hallucinations to hurt self
<input type="checkbox"/>	Self-injurious behavior <i>without</i> suicidal intent	<input type="checkbox"/>	<input type="checkbox"/>	Highly impulsive behavior
Suicidal Ideation Check Most Severe in Past Month			<input type="checkbox"/>	Substance abuse or dependence
<input type="checkbox"/>	Wish to be dead		<input type="checkbox"/>	Agitation or severe anxiety
<input type="checkbox"/>	Suicidal thoughts		<input type="checkbox"/>	Perceived burden on family or others
<input type="checkbox"/>	Suicidal thoughts with method (but without specific plan or intent to act)		<input type="checkbox"/>	Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
<input type="checkbox"/>	Suicidal intent (without specific plan)		<input type="checkbox"/>	Homicidal ideation
<input type="checkbox"/>	Suicidal intent with specific plan		<input type="checkbox"/>	Aggressive behavior towards others
Activating Events (Recent)			<input type="checkbox"/>	Method for suicide available (gun, pills, etc.)
<input type="checkbox"/>	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		<input type="checkbox"/>	Refuses or feels unable to agree to safety plan
Describe:			<input type="checkbox"/>	Sexual abuse (lifetime)
			<input type="checkbox"/>	Family history of suicide (lifetime)
<input type="checkbox"/>	Pending incarceration or homelessness		Protective Factors (Recent)	
<input type="checkbox"/>	Current or pending isolation or feeling alone		<input type="checkbox"/>	Identifies reasons for living
Treatment History			<input type="checkbox"/>	Responsibility to family or others; living with family
<input type="checkbox"/>	Previous psychiatric diagnoses and treatments		<input type="checkbox"/>	Supportive social network or family
<input type="checkbox"/>	Hopeless or dissatisfied with treatment		<input type="checkbox"/>	Fear of death or dying due to pain and suffering
<input type="checkbox"/>	Non-compliant with treatment		<input type="checkbox"/>	Belief that suicide is immoral; high spirituality
<input type="checkbox"/>	Not receiving treatment		<input type="checkbox"/>	Engaged in work or school
Other Risk Factors			Other Protective Factors	
<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			<input type="checkbox"/>	
<input type="checkbox"/>			<input type="checkbox"/>	
Describe any suicidal, self-injurious or aggressive behavior (include dates)				