



# 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

