



# 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

