



Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Client Name: _____ Age: 6 7 8 9 10 11 12

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

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

