| **SUICIDE IDEATION DEFINITIONS AND PROMPTS:** | **Past**  **month** | |
| --- | --- | --- |
| **Ask questions that are in bolded and underlined** | **Yes** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**  Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?  ***Have you wished you were dead or wished you could go to sleep and not wake up?*** |  |  |
| **2) Suicidal Thoughts:**  General non-specific thoughts of wanting to end one’s life/commit suicide, “*I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan*.”  ***Have you actually had any thoughts of killing yourself?*** |  |  |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**  Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “*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.*”  ***Have you been thinking about how you might kill yourself?*** |  |  |
| **4) Suicidal Intent (without Specific Plan):**  Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to “*I have the thoughts but I definitely will not do anything about them*.”  ***Have you had these thoughts and had some intention of acting on them?*** |  |  |
| **5) Suicide Intent with Specific Plan:**  Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.  ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** |  |  |
| **6) Suicide Behavior Question**  ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***  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: *How long ago did you do any of these?***   Over a year ago?  Between three months and a year ago?  Within the last three months? |  |  |

**II. Response Protocol to C-SSRS Screening**

(Linked to last item answered YES)

Item 1 – Mental Health Referral at discharge

Item 2 – Mental Health Referral at discharge

Item 3 – Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures

Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures

Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures

Item 6 – If over a year ago, Mental Health Referral at discharge

If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse)

and Patient Safety Monitor

If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition:  Mental Health Referral at discharge

 Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures

 Psychiatric Consultation and Patient Safety Monitor/ Procedures