| **SUICIDE IDEATION DEFINITIONS AND PROMPTS:**  | **Past** **month** |
| --- | --- |
| **Ask questions that are in bold 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/die by suicide, “*I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan*.” ***Have you had any actual 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 do this?***  |  |  |
| **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: *Was this within the past 3 months?***  | **Lifetime** |
|  |  |
| **Past 3 Months** |
|  |  |

**Response Protocol to C-SSRS Screening** (Linked to last item marked “YES”)

Item 1 Behavioral Health Referral at Discharge

Item 2 Behavioral Health Referral at Discharge

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions

Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions