SUICIDE IDEATION DEFINITIONS AND PROMPTS:		
Ask questions that are bolded and underlined. The remaining information is for staff only.	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. ***In the past week, 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. ***In the past week, have you had any actual thoughts of killing yourself?***		
If YES to 2: Ask Question 3.		
3) Suicidal Thoughts with method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at 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."* ***In the past week, have you been thinking about how you might do this?***		
If NO to 2 or NO to 3, skip to Question 6 and stop there **If YES to Question 3, ask Question 4 and 5, Do NOT ask Question 6**		
4) Suicidal Intent (without specific plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***In the past week, have you had these thoughts and had some intention of acting on them?***		
5) Suicidal 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. ***In the past week, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

PT #:

AS0580

COLUMBIA-SUICIDE SEVERITY RATING SCREEN VERSION

SUICIDE IDEATION DEFINITIONS AND PROMPTS:		
Ask questions that are bolded and underlined. The remaining information is for staff only.	Yes	No
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything with any intent to die?*** Examples: Attempt: Took pills, shot self, cut self, jumped from a tall place; Preparation: Collecting pills, getting a gun, giving valuables away, writing a suicide or goodbye note, etc.) **If YES, ask:** ***How long ago did you do any of these?*** ❒ More than a year ago? ❒ Between a week and a year ago? ❒ Within the last week?		

II. TRHMC 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 more than 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 Consultaiton 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

If reassessment, please identify the stressors since initial C-SSRS assessment. If none, please write NONE in box.

Signature of Nurse/Person Completing Form _____ Date _____ Time _____

Printed Name of Nurse/Person Completing Form _____

PT #:

AS0580

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