COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version – Since Last Contact for Emergency Departments

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Contact**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***<u>Have you been thinking about how you might do this?</u>*** E.g. "*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.*"		
4) ***<u>Have you had these thoughts and had some intention of acting on them?</u>*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***<u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u>***		
6) ***<u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Took pills, tried to shoot yourself, cut yourself, or hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.		

Possible Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Referral at Discharge
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 Immediate Notification