

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening Version – Since Last Contact for Outpatient & Ambulatory

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Contact	
	YES	NO
Ask questions that are bold and <u>underlined</u>		
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
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Referral
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consultation and Patient Safety Precautions