Suicide Screening Questions for the Emergency Department

1. In the past few weeks, have you wished you were dead?
   - ○ Yes
   - ○ No
   - ○ No response

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
   - ○ Yes
   - ○ No
   - ○ No response

3. In the past week, have you been having thoughts about killing yourself?
   - ○ Yes
   - ○ No
   - ○ No response

4. Have you ever tried to kill yourself?
   - ○ Yes
   - ○ No
   - ○ No response

If yes, how?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

When?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Patient Name: ____________________________ Date: ____________________________

Medical Record #: ____________________________
(or Patient Label) ____________________________