Ask the patient:

1. In the past few weeks, have you wished you were dead?  ○ Yes  ○ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  ○ Yes  ○ No
3. In the past week, have you been having thoughts about killing yourself?  ○ Yes  ○ No
4. Have you ever tried to kill yourself?  ○ Yes  ○ No
   If yes, how? ______________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   When? ____________________________________________________________________

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  ○ Yes  ○ No

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - “Yes” to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  - “No” to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255)  En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741