

Illinois DocAssist - Suicide Risk Assessment Charting

MRN: _____

Patient Name: _____

DOB/Age: _____

Suicide Risk Assessment		Date	Date	Date	Date
Risk Factors					
Psychiatric disorder (depression, bipolar, impulsive/ aggressive behavior, anxiety, eating disorders)					
Previous suicide attempt					
Family history of suicidal behavior, psychiatric disorder, substance abuse					
Drug and alcohol use/abuse					
Stressful life events or loss					
Family disruption, conflict, or stress					
Access to lethal methods, especially guns					
History of physical, sexual, or emotional abuse					
Isolation, rejection, or feelings of shame					
Chronic physical illness or condition					
Lesbian/gay/bi-sexual/transgender/(LGBT) & immigrant youth without family/community support					
Hopelessness or despair					
Preoccupation with death/suicide					
Protective Factors					
Family connection and support					
Strongly held religious or cultural beliefs					
Realistic life goals or future plans					
Academic achievement					
No access to lethal means					
Perception of stress as limited, does not blame self for stress					
Community and school connections, support and engagement					
Perceived support					
Suicide Inquiry*					
Ideation					
Plan					
Behaviors					
Intent					
Risk Level Assessment: Low/Moderate/High					
Date: Low/Mod/High	Rationale:	Plan:			
Date: Low/Mod/High	Rationale:	Plan:			
Date: Low/Mod/High	Rationale:	Plan:			
Date: Low/Mod/High	Rationale:	Plan:			

**Refer to second page for further explanation of the suicide inquiry section and risk level assessment.*

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Suicide Inquiry: Specific questioning about thoughts, plans, behaviors, intent

Ideation: frequency, intensity, duration in last 48 hours, past month and worst ever

Plan: timing, location, lethality (method), availability, preparatory acts

Behaviors: past attempts, aborted attempts, rehearsals

Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore ambivalence: reasons to die vs. reasons to live.

Risk Level Assessment: Assessment of risk level should be based on clinical judgment. Document the rationale for the risk level and the plan of care to address/reduce current risk. The plan of care should include disclosure of patient’s suicidal ideation or plan to parents/caregivers. The plan should also include contact numbers for crisis support or possible emergency room intervention.

The combinations below are a general guideline.

Risk Level	Risk/Protective Factors	Suicidality	Possible Interventions
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal attempt or persistent ideation with strong intent or rehearsal	Admission generally indicated. Suicide precautions (i.e. removal of access to methods; continuous supervision by a parent)
Moderate	Multiple risk factors, few protective factors	Ideation with plan, but no intent or behavior	Admission may be necessary. Develop crisis plan (i.e. frequent observation by a parent, involve school staff, numbers for crisis services, plan for transportation to ER)
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction

Please note: This is a PCP/user-friendly tool to assist in assessing the risk of suicidality in adolescents. This resource is not intended to take the place of any discussions with the patient. All suicide assessments need to be conducted directly from clinician to patient.

The following resources were used in the development of this tool: SAFE-T Screening for Mental Health, Inc and the Suicide Prevention Resource Center; Adolescent Health Working Group, Adolescent Provider Toolkit; Guidelines for Adolescent Depression in Primary Care.