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