Mental Health Suicide Assessment Checklist and Action Plan

Student's Name: _____ Date: _____ Interviewer: _____

Student's ID#: _____

(1) Person Referring: _____

Reason for Referral: _____

(2) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts?	Y	N
Have there been suicide attempts by significant others or family members in his or her life?	Y	N
Does the student have a detailed, feasible plan?	Y	N
Has s/he made special arrangements as giving away prized possessions?	Y	N
Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?	Y	N
Does the student have access to lethal means?	Y	N
Does the student struggle with substance abuse?	Y	N

(3) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing severe psychological distress?	Y	N
Have there been major changes in recent behavior along with negative feelings/ thoughts?	Y	N

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(4) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other to help the student survive?	Y	N
Does the student feel alienated?	Y	N

(5) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor impulse control?	Y	N

Has the student attempted suicide in the past? Y N

Has the student used any other forms of self-harm? Y N

*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk.

(6) PLAN OF ACTION

Crisis Referral Necessary Y N

If **yes**, personal/facility contacted _____

Student transported to an emergency facility Y N

If **yes**, date, time, and name of person/facility providing transportation:

_____

Safety Plan Necessary Y N

If **yes**, date, time, name of person who wrote safety plan with student:

_____

Any other supports/family contacted & additional notes:

_____

_____

_____

_____

_____

_____

(7) Any Further Recommendations:

_____

_____

_____

Student Response to Recommendation:

_____

_____

_____

_____

_____

Revised AB 12/21/2018