COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

ASQ BRIEF SUICIDE SAFETY ASSESSMENT

(for Providers)

Praise Patient ***I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."***	
Frequency of Suicidal Thoughts	
In past two (2) weeks have you been thinking about killing yourself? **If YES**, how often? _____	YES ☐ NO ☐
Are you having thoughts of killing yourself right now? **If YES: patient requires immediate transfer to a psychiatric facility, urgent/STAT mental health evaluation and patient cannot be left alone. A positive response indicates imminent risk.**	YES ☐ NO ☐
Suicide Plan	
Assess if the patient has a suicide plan, regardless of how they responded to any other questions. (ask about method and access to means)	
Do you have a plan to kill yourself? **If NO**, If you were going to kill yourself, how would you do it? _____	YES ☐ NO ☐
Past Behavior ***(Strongest predictor of future attempts)***	
Have you ever tried to hurt yourself?	YES ☐ NO ☐
Have you ever tried to kill yourself? **If YES:** How: _____ When: _____ Why: _____	YES ☐ NO ☐
Did you think [method] would kill you?	YES ☐ NO ☐
Did you want to die?	YES ☐ NO ☐

Did you receive medical/physical treatment? Location: _____ Date: _____	YES ☐ NO ☐
Symptoms	
Depression: In past two (2) weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?	YES ☐ NO ☐
Anxiety: In the past two (2) weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?	YES ☐ NO ☐
Impulsivity/Recklessness: Do you often act without thinking?	YES ☐ NO ☐
Hopelessness: In the past two (2) weeks, have you felt hopeless, like things would never get better?	
Irritability: In the past two (2) weeks, have you been feeling more irritable or grouchier than usual?	YES ☐ NO ☐
Substance or alcohol use: In the past two (2) weeks, have you used drugs or alcohol? **If YES:** What: _____ How Much: _____	YES ☐ NO ☐
Other Concerns: Recently, have there been any concerning changes in how you are thinking or feeling? _____	YES ☐ NO ☐
Support & Safety	
Support Network: Is there a trusted person/adult you can talk to?	YES ☐ NO ☐
Have you ever seen a therapist/counselor? **If YES?** When? _____	YES ☐ NO ☐
Safety Question: Do you think you need help to keep yourself safe? (a NO response do not indicate the patient is safe, but a YES is a reason to act immediately to ensure safety)	YES ☐ NO ☐
Reason for living: What are some of the reasons you would **NOT** kill yourself? _____	

Pediatric (≤18 years of age) Assessment/Interview

Say to parent: After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective.

Your child said (reference positive responses on the asQ). Is this something he/she shared with you?	YES ☐ NO ☐
Does your child have a history of suicidal thoughts of behaviors that you're aware of? **If YES**: Please explain: _____	YES ☐ NO ☐
Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?	YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO ☐
Are you comfortable keeping your child safe at home?	YES ☐ NO ☐
How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)? _____	YES ☐ NO ☐
Is there anything you would like to tell me in private? _____	YES ☐ NO ☐

Determine Disposition

After completing the assessment choose the appropriate disposition.

☐ **Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts). Transfer to psychiatric facility. Urgent/STAT mental health evaluation. Keep patient safe in ED.

☐ **No further evaluation in the ED:** Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

- ☐ Send home with mental health outpatient referrals

  OR

- ☐ No further intervention is necessary at this time

Provider Signature: _____ Date/Time: _____