INITIAL SUICIDE AND SELF HARM ASSESSMENT FORM

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Initial Suicide and Self Harm Assessment Form

Student: _____ Date: _____ Time of Incident:_____

Supervisor completing interview: _____ Time of LSI: _____

Incident type:

- ☐ Suicide attempt
- ☐ Suicide threat
- ☐ Self-reported suicidal thoughts
- ☐ Deliberate self harm
- ☐ Deliberate self harm attempt/threat OR risky behavior that places student at risk for self harm
- ☐ Self-reported self harm thoughts

Incident description:

Please include the level of actual harm or level of potential harm. If plan or attempt, was the plan or attempt feasible:

Current Intervention Plans:

Does this student have a specific treatment plan or ICMP intervention related to management of self harm or suicidal statements/behaviors? ☐ yes ☐ no

If yes, summarize the plan:

Immediate Safety Plan:

Include staffing, removal of potentially dangerous items, supervision level, etc.

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Student statement:
What does the student say about this event? Student's intent? Student's plan? Did student want to hurt or kill self?

Summary of findings from the LSI:
Triggers, sore spots, or setting conditions:

Skills and resources student can use:

Supports student wants:

Current risk factors:
Does the student still feel like hurting him/herself after talking with staff? If yes, is he/she willing to follow a safety plan?

Staff observations:
- ☐ Abrupt changes in appearance
- ☐ Recent weight gain or appetite change
- ☐ Sleeplessness or Sleepiness
- ☐ Lethargy, Exhaustion
- ☐ Increased Irritability or Anger
- ☐ Moodiness, Not Communicating
- ☐ Increased risk-taking
- ☐ Recent Accountability Action
- ☐ Recent humiliation or disappointment
- ☐ Recent experience of loss
- ☐ Other: _____

Please describe:

Notifications (choose appropriate section):

- ☐ Event occurred during regular business hours
- ☐ Event occurred after regular business hours

For use during regular business hrs.		
Direct verbal notification to: (indicate name)	Time notified:	By whom:
Program admin:		
Clinician:		
Nurse:		
Clinical admin:		

For use after regular business hrs.		
Direct verbal notification to(indicate name):	Time notified:	By whom:
Program admin on call:		
Clinical admin on call:		
Nurse:		
Send urgent email summary to campus nursing dept, clinical dept, and campus admin group		

Supervisor completing this initial assessment

Print Name _____ Date _____

Signature _____ Time Complete _____

Clinical assessment:

- ☐ Low Risk: No additional safety planning needed at this time
- ☐ Moderate Risk: See Self Harm Intervention Plan
- ☐ High Risk: See Self Harm Intervention Plan
- ☐ Extreme Risk: See Self Harm Intervention Plan and Individual Programming Checklist

Comments:

Print Name _____ Date _____

Signature _____ Time of Assessment _____

SUICIDE/SELF HARM INTERVENTION PLAN

Suicide/Self Harm Intervention Plan

Student Name: _____ **Date:** _____ **Next review:** _____

Safety Concern Episode(s): _____

_____

Current Risk Factors: _____

_____

Current Self-Harm Risk Level: ____ Moderate _____ High _____ Extreme (see IP plan)

Supervision Level

General supervision: _____

Supervision of bathroom: _____

Supervision of bedroom: _____

Supervision during transitions: _____

Room search, how often, items staff are looking for: _____

_____

Person/body search, how often, focus: _____

_____

Other: _____

Safety Interventions

Restrict/remove items: _____

_____

Verbal check-in's, how often, focus: _____

_____

Supports, skills, distress tolerance: _____

_____

Self-harm behavior management plan: _____

_____

Other Modifications: _____

Crisis Team Involvement

☐ **Yes:** _____

☐ **No:** _____