MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
HOSPITAL PLAN FOR THE PROVISION OF PATIENT CARE	NAVHOSPPNCLAINST 3000.1C	15 Mar 2011

LOCAL FORM TITLE *(Optional)*
SUICIDE RISK ASSESSMENT

Date: _____ **Time:** _____

☐ Emergency Department
☐ SARP

Risk Level	High	Moderate	Low
	*All three factors present	***D** paired with **C** or I	*Any factor presenting alone

Core Risk Factors

Key: D = Desire C = Capability I = Intent

Desire			
	Are you currently having any thoughts of suicide or told anyone that you are going to commit suicide?	☐ Yes	☐ No
	Do you have any current thoughts of wanting to kill or harm someone?	☐ Yes	☐ No

(Describe)

Capability			
	Have you ever attempted to commit suicide? If "yes", when?	☐ Yes	☐ No
	Does the patient have any of the below risk factors?	☐ Yes	☐ No

(Check applicable risk factors)

- ☐ History of violence to others
- ☐ Exposure to someone else's death by suicide
- ☐ Availability of means
- ☐ Extreme rage
- ☐ Current intoxication
- ☐ Tendency toward frequent intoxication
- ☐ Increased agitation
- ☐ Decreased sleep
- ☐ Recent dramatic mood changes
- ☐ Acute symptoms of mental illness
- ☐ Out of touch with reality

Intent			
	In the past month, have you made any plans or considered a method that you might use to kill yourself?	☐ Yes	☐ No

Preparatory behavior:

Expressed intent to die: ☐ Yes ☐ No

Patient Safety Plan

☐ 1:1 Watch	☐ Placed in safe room	☐ Placed in gown

Interviewer's signature/title _____

Escort's name/command (print) _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	