

## Triage Intake Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: \_\_\_\_\_

School: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Contact Number: \_\_\_\_\_

What is the reason for the referral?

1. Level of depression in the past 24 hours? (1 – 10)      Past hour? (1 – 10)

2. How safe do you feel right now? (1 – 10)

3. Are you thinking of killing yourself? (Y or N)

4. If yes, do you have a plan? (Y or N)      When?      How?

5. Are there weapons in your home? (Y or N)

6. Do you have access to them? (Y or N)

7. On a scale of 1 – 10, how serious are you about the threat?

8. Have you or any family member or friend ever attempted suicide?

9. Any recent changes in eating / sleeping patterns?

10. Have you ever been treated for mental health issues before?

11. If so, where, when, and for what?

12. Are you taking any medications regularly? (Y or N)

13. If yes, did you take them today?

14. Have you used any illegal drugs in the past 24 hours? (Y or N)

15. Do you have a history of illegal drug use? (Y or N)

16. Who is an adult you feel you can talk freely with?

SFRD Signature: \_\_\_\_\_