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. **Have you been involved in risky/dangerous behavior in the past 48 hours? (Y or N)**
17. **Do you have a Health Plan (Allergies, Disease, Asthma) If yes, what?**
18. **Who is an adult you feel you can talk freely with?**

SFRD Signature: _____