RSU5 SUICIDE SCREENING FORM

1. IDENTIFYING INFORMATION

Name:_____ ID_____ School: _____ D.O.B._____ Age:____

IEP/504:_____ Address:_____

Parent/Guardian #1 name/phone # (s)_____

Parent/Guardian #2 name/phone # (s):_____

Screener's name:_____ Position:_____ Contact info:_____

Screener Consulted with:_____ at the school.

2. REFERRAL INFORMATION

Who reported concern/Contact info: _____ Self Peer Staff Parent/Guardian Other

What information did this person share that raised concern about suicide risk?_____

3. INTERVIEW WITH STUDENT

A. Does student exhibit any of the following warning signs?

- ☐ Written statements, poetry, stories, electronic media about suicide
- ☐ Withdrawal from others
- ☐ Preoccupation with death
- ☐ Feelings of hopelessness
- ☐ Substance Abuse/Mental Health Issues
- ☐ Current psychological/emotional pain
- ☐ Discipline problems
- ☐ Conflict with others (friends/family)
- ☐ Other signs:
- ☐ Experiencing bullying or being a bully
- ☐ Recent personal or family loss or change (i.e., death, divorce)
- ☐ Recent changes in appetite
- ☐ Family problems
- ☐ Giving away possessions
- ☐ Current trauma (domestic/relational/sexual abuse)
- ☐ Crisis within the last 2 weeks

- Does the student admit to thinking about suicide? Yes ☐ No ☐
- Does the student admit to thinking about harming others? Yes ☐ No ☐
- Does the student admit to having a plan? Yes ☐ No ☐

If so, what is the plan (how, when, where)?_____

- Is the method available to carry out the plan? Yes ☐ No ☐ Explain: _____
- Is there a history of previous gesture(s) or attempt(s)? Yes ☐ No ☐ If yes, describe: _____
- Is there a family history of suicide? Yes ☐ No ☐ Explain:
- Has the student been exposed to suicide by others? Yes ☐ No ☐ Explain: _____
- Has the student been recently discharged from psychiatric care? Yes ☐ No ☐ Date/Explain:

B. Does the student have a support system? Yes ☐ No ☐

List the names of family members:_____

Peers:_____

Others:_____

C. Protective Factors:_____

4. PARENT/GUARDIAN CONTACT

1. Name of parent/guardian contacted:_____ Date Contacted:_____

2. Was the parent/guardian aware of the student's suicidal thoughts/plans? Yes ☐ No ☐

3. Parent/guardian's perception of threat?_____

5. SHORT TERM ACTIONS TAKEN

☐ Contacted Parent/Guardian _____ ☐ Released to Parent /Guardian ☐ Parent/Guardian takes child to hospital Yes No	☐ Parent/Guardian schedules mental health evaluation appointment Yes No ☐ Notes:
☐ Release Back to Class after Parent- and/or Agency-Confirmed Plan and School Follow Up Plan Established Notes:	
☐ Provided student and family with resource materials (e.g. Teen Pocket Directory) and phone numbers (e.g. 1-888-568-1112 (Voice) (Crisis Hotline) 711 (Maine Relay), National Suicide Prevention Lifeline: 1-800-273-TALK, Trevor Project for LGBT Youth 1-866-488-7386)	
☐ School Counselor/School Psychologist/School Nurse Follow Up with Student Date and Time:	
☐ School Administrator Notified Date/Time:	

6. INTERMEDIATE ACTIONS TAKEN (Check all the apply) *** obtain Release of Information**

Agency	Contact Date/Time/Name/Info	Recommendations
☐ Call 911 if immediate danger		
☐ Current Therapist*		

☐ **NO FURTHER FOLLOW-UP NEEDED** (limited or no risk factors, *and* NO starred* risk factors from section 3 A).

☐ **Several risk factors noted, suicide ideation denied, check in by:** _____

7. LONG-TERM PLAN (SCHOOL AND COMMUNITY) Check All that Apply

Action	Person/s Responsible and/or Notes
☐ Arrange Mental Health/Suicide Risk Assessment Date of Request: Date of Assessment: Date of Follow-Up Meeting from Mental Health/Risk Assessment with School Team:	Name/Contact info of QMHP (Qualified Mental Health Professional):
☐ Student Safety Plan completed and distributed (if concerns about student's safety) Date of Follow-Up Meeting for Safety Plan with School Team:	Meeting Participants:
☐ Referred to Special Education Child Find/Contact School Psychologist Date of Follow-Up Meeting for Child Find Meeting with School Team or if held simultaneously, date of the 60 day follow up for Child Find:	Meeting Participants:
☐ Referred to Student Support Team/Student Information Team/Tier Two Intervention o Check and Connect/Check In - Check Out o School Support Group o Tier Two Intervention:	Notes on facilitators/times/specific interventions:
☐ Informed Relevant School Staff of Follow-up Actions	
☐ Release of Information Obtained for Agency/Community Providers	
☐ Inpatient Hospitalization (after screening) ☐ Release of Information	
☐ Local Emergency Room (after screening) ☐ Release of Information	
☐ Referred to/already seeing qualified mental health professional (outpatient) Therapist Name/Contact information: Release of Information:	
Other (list)/Notes:	

*** Use N/A if not applicable
*** Use DNK for Do Not Know