Youth Suicide Risk Screening Form

Student name _____ Date of screen _____

	Past 24 hours	Past week	Past Month
1. Have you wished you were dead?	☐	☐	☐
2. Have you felt that you, your friends, or your family would be better off if you were dead?	☐	☐	☐
3. Have you had thoughts about killing yourself?	☐	☐	☐
4. Have you tried to kill yourself? ☐ No ☐ Yes	☐	☐	☐
a. If yes, how?			
b. If yes, when and where?			
c. Did you stop yourself, or did someone stop you?			
d. How do you feel now that they stopped you?			
5. Do you plan to kill yourself? ☐ No ☐ Yes			
a. If yes, how, when, and where?			

If student checks "past 24 hours" or "past week" to any question, reports a suicide attempt at any time, or checks "yes" to question 5, a full suicide risk assessment **must** be conducted for safety. This may be done by school-based mental health staff or by referral based on school district policy.

Parents contacted? ☐ Yes ☐ No
Full assessment completed by school staff? ☐ Yes ☐ No
Outside referral for assessment made? ☐ Yes ☐ No

Referred to: _____ Phone: _____
Email: _____

_____ _____
Screener name and credentials Date

Adapted from the Ask Suicide-Screening Questions form (ASQ; Horowitz, 2012), the Columbia Suicide Severity Rating Scale (C-SSRS; Posner, 2009) and the Suicide Ideation Questionnaire-JR (SIQ-JR; Reynolds, 1997).