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).

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