

SiS: Suicide in Schools Model Youth Suicide Risk Screening Form 2.0

Student name _____ Date of screen _____
 Completed by (Name/title) _____
 Reason for completing this form _____

	Past 24 hours	Past week	Past Month+
1. Have you ever wished you were dead?	No		
2. Have you ever felt that you, your friends, or your family would be better off if you were dead or gone?	No		
3. Have you ever had thoughts about killing yourself?	No		
4. Have you tried to kill yourself?	No		
a. If yes, how, when, where, and why? _____			
b. Did you stop yourself, or did someone else stop you? _____			
c. How do you feel now that they stopped you? _____			
5. Do you plan to kill yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes			
a. If yes, how, when, and where? _____			

If the student answers YES to any question, a comprehensive suicide risk assessment should be completed either by school-based mental health staff or by referral based upon school district policy. It is recommended that parents are contacted in all cases where a screening is conducted, even if a student denies risk. It is also important to consult with other school staff on suicide risk cases, such as other school-based mental health professionals (SMHP), a Suicide Prevention Coordinator (SPC), crisis team members, and/or administrators.

Name of parent contacted _____ Date _____ Time _____

If Parent unreachable, list person/agency contacted _____

If yes to any question, referred to school staff for Suicide Risk Assessment? ☐ Yes ☐ No

Outside referral for assessment made? ☐ Yes ☐ No

Consulted with other SMHP, SPC, crisis team member or administrator? ☐ 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).*