

SCREENING FOR SUICIDE & OTHER CAUSES OF DEPRESSIVE SYMPTOMS

Patient Name: _____ DOB: _____ Date: _____

SUICIDE SCREENING - If question 1 is negative and suspicion is low, subsequent questions can be skipped		YES	NO
1	Have these symptoms/feelings lead you to think you might be better off dead?		
2	This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?		
3	What about thoughts about hurting or even killing yourself? (If YES ask #4)		
4	Have you actually done anything to hurt yourself?		
5	Identify the following RISK FACTORS for suicide:		
	a. History of Suicide Attempt?		
	b. Feelings of Social Isolation?		
	c. History of or current Substance Abuse?		
	d. Feelings of Hopelessness?		
	e. Significant Comorbid Anxiety?		

GRIEF REACTION SCREENING		YES	NO
1	Did your most recent period of feeling depressed or sad begin after someone close to you died?		
2	If so, did the death occur more than 2 months ago?		
If "NO" to first question, or if "YES" to both questions, treat the patient for depression.			

MANIA SCREENING - rule out Bi Polar Disorder		YES	NO
1	Has there ever been a period of at least four days when you were so happy or excited that you got into trouble, or your family or friends worried about it or a doctor said you were manic?		
A "yes" response indicates potential bipolar disorder. Assess further for mania.			
2	Diagnostic criteria include the concurrent presence of at least 4 of the following symptoms (one of which must be the first symptom listed):		
	a. A Distinct Period of Abnormal, Persistently Elevated, Expansive, or Irritable Mood		
	b. Less Need for Sleep		
	c. Inflated Self-Esteem / Grandiosity		
	d. More Talkative than usual (pressured speech)		
	e. Distractibility		
	f. Increased Goal-Directed Activity or Psychomotor Agitation		
9	Excessive involvement in pleasurable activities without regard for negative consequences (e.g., buying sprees, sexual promiscuity)		

ALCOHOL USE / ABUSE SCREENING (CAGE):		YES	NO
1	Have you ever felt you ought to CUT DOWN on your drinking?		
2	Have people ANNOYED you by criticizing your drinking?		
3	Have you ever felt Bad or GUILTY about your drinking?		
4	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)?		
Two or more "yes" responses are positive for possible alcohol abuse.			

<p>Action Taken:</p> <p><input type="checkbox"/> Screening negative; no further action required</p> <p><input type="checkbox"/> Positive Screening; medication prescribed</p> <p><input type="checkbox"/> Positive Screening; medication prescribed and referral to staff for Phone Protocol</p> <p><input type="checkbox"/> Positive Screening; patient referred to Mental Health Provider</p> <p style="margin-left: 20px;">Name of MH Provider: _____</p> <p>Comments:</p> <p>_____</p> <p>_____</p>

