Southern Health Santé Sud

ADDRESSOGRAPH OR LABEL

SUICIDE RISK SCREENING TOOL

Instructions for completion on the back.

Part A : To be answered by the resident.

Complete the following assessment with the resident. If the resident is cognitively impaired and unable to answer the questions, **proceed to Part B.**

☐ Resident is unable to answer the questions. — Circle one

Ask:	**Do you feel unsafe right now?**	YES / NO
Ask:	**Do you ever think about hurting or harming yourself?**	YES / NO
	If yes, what would you do:	
Ask:	**Have you ever intentionally hurt yourself, or attempted suicide?**	YES / NO
	If so, what did you do:	

If Part A is completed with the resident, proceed to “Part C”.

Part B: To be answered by the resident’s substitute decision maker.

Complete the following assessment with the resident’s substitute decision maker.

Ask:	**Has the resident communicated to you feelings of being unsafe here?**	YES / NO
Ask:	**Has the resident ever communicated to you thoughts about hurting or harming him/herself?**	YES / NO
	If yes, what would he/she do?	
Ask:	**To your knowledge, has the resident ever intentionally hurt him/herself or attempted suicide?**	YES / NO
	If so, what did he/she do?	

Proceed to Part C.

Part C: Collateral Information

Is there collateral information (e.g. Application/Assessment, health records, consults, family, other), indicating a risk for suicide? — YES / NO

If yes, summarize key factors in the space below and completed the ***Risk Assessment for Suicide Tool (RAST).***

Part D: Risk Rating

☐ If “Yes” to any of the questions in Part A, B or C resident is at risk for suicide, complete the ***Risk Assessment for Suicide Tool (RAST)*** **OR**

☐ No foreseeable risk.

Completed by (name, signature and designation):

Date and time:

Instructions for Use:

1. This is a screening tool, ***used on admission only***, to assist the health care team in Personal Care Homes to determine a resident's level of suicide risk and to assist in the provision of appropriate clinical care and management of suicide risk.

2. Complete within 24 – 48 hours of a resident's admission for initial screening.

3. Complete Part A with the resident. Circle the appropriate answer for each question. If the resident answers "Yes" to any of the questions, use the space provided to hand-write pertinent information that expands on suicide thoughts and behaviours.

   If the resident is cognitively impaired and unable to answer the questions indicate this by placing a check mark in the box "Resident is unable to answer the questions" and proceed to Part B.

   If Part A is completed with the resident, proceed to Part C.

4. Complete Part C "Collateral Information". Circle the appropriate answer (YES/NO, determining the level of risk. If "At Risk" completed the RAST (CLI.6410.PL.021.FORM.02) .

5. File the suicide risk screening tool in the resident's health record.