

PATIENT SAFETY SCREENER

This screener should be administered by the obstetric care clinician. For additional information on assessment and intervention, see page 22 of the Lifeline for Moms Obstetric Care Clinician Algorithms, Assessing Risk of Suicide.

*A patient presenting with a current suicide attempt is an automatic Yes on Items 2, 3, 4, 5, and 6.

A. DETECTION (PRIMARY SCREENING)			
<i>Ask the following questions exactly as worded. If collateral information indicates ideation or attempt, document a "yes".</i>			
1. In the past two weeks, have you felt down, depressed, or hopeless? <i>(Not necessary to ask if PHQ9 was already administered – score it based on PHQ9 Item 2 response. 0=No, >0=Yes)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient unable to complete <input type="checkbox"/> Patient refused			
2. In the past two weeks, have you had thoughts of killing yourself? * <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient unable to complete <input type="checkbox"/> Patient refused			
3. In your lifetime, have you ever attempted to kill yourself? * <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Patient unable to complete <input type="checkbox"/> Patient refused			
3a. If yes, when did this happen? <input type="checkbox"/> Within past 24 hours (including today) <input type="checkbox"/> Within last month (but not today) <input type="checkbox"/> Between 1 and 6 months ago <input type="checkbox"/> More than 6 months ago <input type="checkbox"/> Patient unable to complete <input type="checkbox"/> Patient refused			
B. DETECTION RESULT			
<i>"Yes" to Item 2 (ideation) OR "Within past 24 hours", "Within last month" or "Between 1 and 6 months ago" to Item 3a = <input type="checkbox"/> Positive screen -> Proceed to C. Stratification</i>			
C. STRATIFICATION (SECONDARY SCREENING)			
<i>Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations.</i>			
	Yes	No	Unable to complete
4. Did the patient screen positive on BOTH active ideation AND a past suicide attempt	1	0	
5. Has the individual begun a suicide plan? <i>"Have you been thinking about how you might kill yourself?"</i>	1	0	
6. Has the individual recently had intent to act on his/her ideation? <i>Do you think you might act on your thoughts?</i>	1	0	
7. Has the patient ever had a psychiatric hospitalization? <i>Have you ever been hospitalized for a mental health or substance abuse problem?</i>	1	0	
8. Does the patient have a pattern of excessive substance use? <i>Has drinking or drug abuse ever been a problem for you?</i>	1	0	
9. Is the patient irritable, agitated, or aggressive? <i>Note: This is an observation</i>	1	0	
<i>Sum score (1 for each "Yes")</i>	Total:		

Risk level based on **highest** level category endorsed: Mild Moderate High

D. STRATIFICATION RESULT			
	Mild risk	Moderate risk	High risk
Score from Section C	<input type="checkbox"/> 0 – 2	<input type="checkbox"/> 3 – 4	<input type="checkbox"/> 5 – 6
Critical items		<input type="checkbox"/> Suicide plan or intent (not both)	<input type="checkbox"/> Suicide plan and intent <input type="checkbox"/> Current attempt

Notes: