FL LINC Project Suicide Triage Form

Client Name _____ Date _____

Client ID Number _____

RISK FACTORS	WARNING SIGNS	PROTECTIVE FACTORS
☐ Access to Lethal Means	☐ Change in Behavior (Positive or Negative)	☐ Access to Medical Healthcare
☐ Family History of Mental Health Disorder or Suicide	☐ Change in Sleep	☐ Access to Mental Health Services
☐ Financial Issues or Concerns	☐ Hopelessness About Future or Feeling Trapped	☐ Access to Supportive Services
☐ History of Anger or Hostility	☐ Increase in Anger, Hostility, or Agitation	☐ Career or Work Responsibilities
☐ History of Risky or Reckless Behavior	☐ Increase in Frequency or Severity of Non Suicidal Self Injury (NSSI)	☐ Coping Skills Present
☐ History of Self-Harm Behavior (NSSI) Current or Past	☐ Increase of Substance Use or Abuse	☐ Future Goals/Outlook
☐ History of Substance Abuse	☐ Making Plans to Hurt or Kill Others	☐ Hobbies or Interests
☐ History of Trauma/Victimization	☐ Making Plans to Hurt or Kill Self	☐ Mentors/Role Models
☐ Lack Connectivity/Feeling Alone	☐ Recent Careless, Risky, or Reckless Behavior	☐ Past Mental Health Treatment
☐ Legal Issues	☐ Recent Suicide Attempt	☐ Responsible for Children/Others
☐ LGBTQ Issues	☐ Seeking Access to Means to Kill Others	☐ Responsible for Pets
☐ Mood Disorder—Current or Past	☐ Seeking Access to Means to Kill Self	☐ Spirituality or Religious Beliefs
☐ Perceived Burdensomeness	☐ Severe/Overwhelming Emotional Pain	☐ Supportive Family
☐ Personal Loss (Death, Social Status)	☐ Threatening to Hurt or Kill Others	☐ Supportive Friends
☐ Previous Suicide Attempt	☐ Threatening to Hurt or Kill Self	
☐ Relationship Conflicts	☐ Withdrawal from Family or Activities	

Notes:

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

EXPLORING SUICIDAL THOUGHTS

Questions from the Columbia-Suicide Severity Rating Scale (C-SSRS):

	YES	NO
Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
Have you actually had any thoughts of killing yourself?	☐	☐
Have you been thinking about how you might do this?	☐	☐
Have you had these thoughts and had some intention of acting on them?	☐	☐
Have you started to work out or worked out the details of how to kill yourself?	☐	☐
Do you intend to carry out this plan?	☐	☐
Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐	☐
How long ago did you do any of these?	_____	
Have you hurt yourself **without** wanting to die?	☐	☐

How many times in the past 7 days have you hurt yourself **without** wanting to die? _____

What have you done or used to hurt yourself **without** wanting to die?_____

If **YES** is answered to any of the above questions, behavioral health care consultation and clinical follow-up care is needed.

NOTES:

REFERRAL SOURCES & LINKAGES

SOCIAL SUPPORT SERVICES

- ☐ Academic Tutoring/Mentoring
- ☐ Child Care/Day Care
- ☐ Criminal Justice/Public Safety Services
- ☐ Department of Children and Family
- ☐ Department of Juvenile Justice
- ☐ Employment Assistance
- ☐ Family Planning/Maternal Services (WIC)
- ☐ Financial or Tax Assistance
- ☐ Food Assistance/Pantry
- ☐ Foster/Adoptive Child Services
- ☐ Housing/Shelter Assistance
- ☐ Respite Services
- ☐ Senior Care/Assisted Living
- ☐ Social Assistance Programs
- ☐ Transportation
- ☐ Utility Assistance Programs

BEHAVIORAL HEALTH CARE

- ☐ AIDS/HIV Services
- ☐ Crisis Intervention Services
- ☐ Grief and Loss Support
- ☐ Home-Based Behavioral Health Services
- ☐ Medication Management
- ☐ Mental Health and Counseling Services
- ☐ Peer to Peer Support/Groups
- ☐ Primary Medical Health Care
- ☐ Public Health Services (Vaccination, Screening)
- ☐ Residential Services
- ☐ Substance Abuse Services
- ☐ Tele-Behavioral Health Services

PERSONAL SUPPORT

- ☐ Faith-Based Counseling or Groups
- ☐ Mindfulness Activities or Spiritual Care
- ☐ Physical Health Activities
- ☐ Recreational Activities

☐ Referred for further consultation

_____

Initials Date