SAMPLE DOCUMENTATION OF SUICIDE RISK INTERVENTION

Student Name: ____________________________ Date: ________________

Date of Birth: __________________________ Grade: ______ Gender: m f

Ethnicity:
- American Indian ___ Asian ___ Black ___ White ___ Hispanic ___

Special Education: y n Disability Category: __________

School: ______________________________________

Form completed by:

(must be school psychologist, social worker &/or counselor)

Referred by: ______________________________________

Reason for Assessment: ______________________________________

Required Actions:

☐ Suicide assessment team process implemented
Participants: minimum of 2 staff members must be part of the assessment team.
Team must include mental health &/or counselor. All participants must initial.

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<th>Name</th>
<th>Position</th>
<th>Initial</th>
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☐ Mental health/counselor contact with student
☐ Student supervised until released
☐ Student released

To parent __________________________ Transported by: ______________

Therapist __________________________ Transported by: ______________

ER/hospital __________________________ Transported by: ______________

Other ________________________________

Returned to class (low risk only and w/ parent permission) ______________

☐ Parents notified Time: ______________ Spoke to: ______________________

☐ Referrals given to parents

☐ Discussion of home safety/supervision (access to weapons, drugs, Rx’s, etc.)

☐ “Tips for Keeping Your Child Safe” provided to parent

☐ Outpatient therapist/MD notified (if applicable)

☐ Other ________________________________  

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Safety plan and supportive measures:

Level of concern: □ low □ medium □ high

Safety plan was established with □ student □ school □ family

☐ No harm to self contract: _______________________________________

☐ Identified supports at school:
  1. ___________________________________________________________
  2. ___________________________________________________________

☐ Emergency resources/supports (if after school hours):
  1. ___________________________________________________________
  2. ___________________________________________________________

☐ Outpatient resources given:
  1. ___________________________________________________________
  2. ___________________________________________________________

☐ Participation in community-based services:
  Name of outpatient therapist ___________________________________
  Number of op therapist: ________________________________________
  ☐ Release of information signed

☐ Participate in school-based program:
  _____________________________________________________________
  _____________________________________________________________

☐ Other _______________________________________________________
  _____________________________________________________________

Follow-up plan:

Follow-up plan will be coordinated with parents by:
  ☐ counselor ☐ mental health ☐ administrator
  ☐ other: ______________________________________________________

School contact person: ___________________________ Phone: __________

Plan: __________________________________________________________
  _____________________________________________________________
  _____________________________________________________________

Other comments/concerns:
  _____________________________________________________________
  _____________________________________________________________

Keep original in a confidential centralized location within building.

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Document “Code SRI-__ (Level=L, M, H)” and date in student’s health record.
Give/send copy of this report to parent(s)/guardian(s).
Provide parent with “Tips for Keeping Your Child Safe”.

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