Name: _____ Date: _____Time: _____

PATIENT SAFETY SCREENER

This screener should be administered by the obstetric care clinician. For additional information on assessment and intervention, see page 7 of the Lifeline for Moms Obstetric Care Clinician Algorithms, Assessing Risk of Suicide.

A. DETECTION (PRIMARY SCREENING)

Ask the following questions exactly as worded. If collateral information indicates ideation or attempt, document a "yes".

1. In the past two weeks, have you felt down, depressed, or hopeless? *(Not necessary to ask if PHQ9 was already administered – score it based on PHQ9 Item 2 response. 0=No, >0=Yes)*

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

2. In the past two weeks, have you had thoughts of killing yourself? *

☐ **Yes** ☐ No ☐ Patient unable to complete ☐ Patient refused

3. In your lifetime, have you ever attempted to kill yourself? *

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

3a. If yes, when did this happen?

☐ Within past 24 hours (including today) ☐ Within last month (but not today) ☐ Between 1 and 6 months ago

☐ More than 6 months ago ☐ Patient unable to complete ☐ Patient refused

B. DETECTION RESULT

"Yes" to Item 2 (ideation) OR "Within past 24 hours", "Within last month" or "Between 1 and 6 months ago" to Item 3a = ☐ Positive screen -> Proceed to C. Stratification

C. STRATIFICATION (SECONDARY SCREENING)

Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations.

	Yes	No	Unable to complete
4. Did the patient screen positive on BOTH active ideation AND a past suicide a past suicide attempt	1	0	
5. Has the individual begun a suicide plan? *"Have you been thinking about how you might kill yourself?"*	1	0	
6. Has the individual recently had intent to act on his/her ideation? *Do you think you might act on your thoughts?*	1	0	
7. Has the patient ever had a psychiatric hospitalization? *Have you ever been hospitalized for a mental health or substance abuse problem?*	1	0	
8. Does the patient have a pattern of excessive substance use? *Has drinking or drug abuse ever been a problem for you?*	1	0	
9. Is the patient irritable, agitated, or aggressive? *Note: This is an observation*	1	0	
Sum score (1 for each "Yes") **Total:**			

D. STRATIFICATION RESULT

	Mild risk	Moderate risk	High risk
Score from Section C	☐ 0 – 2	☐ 3 – 4	☐ 5 – 6
Critical items		☐ Suicide plan **or** intent (not both)	☐ Suicide plan **and** intent
			☐ Current attempt

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

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

Notes:

Boudreaux, E. D., Larkin, C., Camargo Jr, C. A., & Miller, I. W. (2020). Validation of a secondary screener for suicide risk: results from the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE). *The Joint Commission Journal on Quality and Patient Safety*, *46*(6), 342-352.