Examples of Suicide Risk Screening Questionnaire and Suicide Assessment Form

Appendix D

Patient Health Questionnaire: PHQ-2 and PHQ-9

The nine item PHQ-9 questionnaire is one of five modules of the Patient Health Questionnaire (PHQ) which covers common type of mental disorders. Each answer is scored 0 to 3, providing a 0 to 27 severity score. The PHQ-2 refers to the first two questions of the PHQ-9, which serve as an ultra-brief depression screener and provides a total score of 0 to 6.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

... Not difficult at all
... Somewhat difficult
... Very difficult
... Extremely difficult

Source: Spitzer RL, Williams JBW, Kroenke K. Patient Health Questionnaire (PHQ) Screeners. Patient Health Questionnaire-9 (PHQ-9). http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf.

Case Management Information System (CMIS) Suicide Assessment Form

1. Have you ever attempted to harm yourself
   If Yes, moderate to high risk. Communicate information to PCP immediately.

2. In the past month, have you made any plans or considered a method that you might use to harm yourself?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

3. There is a difference between having a thought and acting on a thought. Do you think you may actually make an attempt to hurt yourself in the near future?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

4. In the past month, have you told anyone that you were going to commit suicide, or threatened that you might do it?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

5. Do you think there is any risk that you might hurt yourself before you see your doctor/me the next time?
   If Yes, acute risk. Contact PCP and BH provider immediately. If risk appears immediate, stay on phone with patient, call 911 or do your best to make sure the patient goes to the ER immediately. Consider Mobile Crisis Management.

If the response to ALL items, 1-5 is No, the patient is considered at "Low Risk" for suicide. Information should be communicated to the PCP via usual reporting channels in the usual way.

Source: Community Care of North Carolina. Disease Management Model for Depression. https://www.communitycarenc.org/media/related-downloads/depression-toolkit.pdf. Published April 2012. Accessed June 7, 2012.