Suicide Risk Assessment Form

Patient Information

Name

Date of Birth

Patient ID / MRN

Current Status

Reason for Assessment

Presenting Problem/Concern

Suicidal Thoughts

Has the patient expressed suicidal thoughts?

If yes, provide details (frequency, duration, intensity):

Plan & Intent

Does the patient have a plan?

Does the patient have intent to act on the plan?

Plan Details:

History

Any history of suicide attempts?

Any history of self-harm?

Family history of suicide?

Protective Factors

List any protective factors (e.g., family support, reasons for living):

Clinician Assessment

Risk Level

Clinical Impression / Comments