Rationale for Suicide Risk Assessment (i.e. positive screen, new or worsening mental health concerns, repeat assessment for patient at elevated risk for suicide, concerned family member)

HISTORICAL INFORMATION

History of Suicide Attempts (number of attempts, most recent attempt, method, lethality, efforts to seclude, emotional reaction to surviving attempt) **Y/N**

History of Suicidal Ideation, Intent or Plan, Preparatory Behaviour Y/N

History of Deliberate Self-Harm (description of behaviour, onset, frequency, intensity, triggers, explanatory model)

Non-Modifiable Risk Factors (gender, age, race, sexual orientation or identity, family history of suicide-related behaviour, history of trauma)

CURRENT RISK

Suicidal Ideation, Intent and Plan, Preparatory Behaviour within the last month; Access to Firearms (or since last visit) Y/N

Suicide Attempts or Deliberate Self-Harm within the last month (or since the last visit) Y/N

Acute Risk Factors (mental health concerns, substance use, relationship, legal or financial stress, recent trauma) **Y/N**

Warning Signs (agitation, worsening insomnia, irritability, anxiety, hopelessness, suicidal communication, psychosis including command hallucinations, planning for carrying out suicide plan, making arrangements for death, worsening substance use or intoxication) **Y/N**

Protective Factors (personal factors, social supports, religious or spiritual supports, engagement in treatment, ability to safety plan) **Y/N**

Collateral Information Obtained Y/N (rationale for same)

FORMULATION AND PLAN

Risk Formulation:

Risk Status: (patient's risk compared to general population, outpatients, inpatients)

Risk State: (patient's risk compared to their own baseline and other points in their history)

Safety and Treatment Plan: