RPMS Suicide Reporting Form

Local Case Number:		Health Record Number:	
Date Form Completed:		DOB/Age:	
Provider Name:		Sex (M/F):	
Date of Act:		Community Where Act Occurred:	

	Employment Status
	Part-time
	Full-time
	Self-employed
	Unemployed
	Student
	Student and employed
	Retired
	Unknown

	Relationship Status
	Single
	Married
	Divorced/Separated
	Widowed
	Cohabitating/Common-Law
	Same Sex Partnership
	Unknown

	Education
	High School Graduate/GED
	Less than High School, highest grade complete
	Some College/Technical
	College Graduate
	Post Graduate
	Unknown

	Suicidal Behavior
	Ideation with Plan and Intent
	Attempt
	Completed Suicide
	Att'd Suicide w/ Att'd Homicide
	Att'd Suicide w/ Compl Homicide
	Compl Suicide w/ Att'd Homicide
	Compl Suicide w/ Compl Homicide

	Location of Act
	Home or Vicinity
	School
	Work
	Jail/Prison/Detention
	Treatment Facility
	Medical Facility
	Unknown
	Other (specify):

	Previous Attempts
	0
	1
	2
	3 or more
	Unknown

	Method (☑ all that apply)				
	Gunshot		Overdose List:		Non-prescribed opiates (e.g. Heroin)
	Hanging		Aspirin/Aspirin-like medication		Sedatives/Benzodiazepines/Barbiturates
	Motor Vehicle		Acetaminophen (e.g. Tylenol)		Alcohol
	Jumping		Tricyclic Antidepressant (TCA)		Other Prescription Medication (specify):
	Stabbing/Laceration		Other Antidepressant (specify):		Other Over-the-counter Medication (specify):
	Carbon Monoxide		Amphetamine/Stimulant		Other (specify):
	Overdosed Using (select from list)		Prescribed Opiates (e.g., Narcotics)		
	Unknown				
	Other (specify):				

	Substances Involved (☑ all that apply)				
	None		Alcohol		Inhalants
	Alcohol & Other Drugs (select from list)		Amphetamine/Stimulant		Non-Prescribed Opiates (e.g. Heroin)
	Unknown		Cannabis (Marijuana)		Prescribed Opiates (e.g. Narcotics)
			Cocaine		Sedatives/Benzodiazepines/Barbiturates
			Hallucinogens		Other (specify):

	Contributing Factors (☑ all that apply)				
	Suicide of Friend or Relative		History of Substance Abuse/Dependency		Bullying
	Death of Friend or Relative		Financial Stress		Legal
	Victim of Abuse (Current)		History of Mental Illness		Unknown
	Victim of Abuse (Past)		History of Physical Illness		Other (specify):
	Occupational/Educational Problem		Divorce/Separation/Break-up		

	Disposition	Narrative
	Mental Health Follow-up	
	Alcohol/Substance Abuse Follow-up	
	Inpatient MH Treatment Voluntary	
	Inpatient MH Treatment Involuntary	
	Medical Treatment (ED or In-patient)	
	Outreach to Family/School/Community	
	Unknown	
	Other (specify):	

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Instructions for Completing

This form is intended as a data collection tool only. It does not replace documentation of clinical care in the medical record and it is not a referral form. HRN, Date of Act, and Provider Name are required fields. If the information requested is not known or not listed as an option, choose "Unknown" or "Other" (with specification) as appropriate. The form can be partially completed, saved, and completed at a later time if needed.

LOCAL CASE NUMBER
Indicate internal tracking number if used, not required.

DATE FORM COMPLETED
Indicate the date the Suicide Reporting Form was completed.

PROVIDER NAME
Record the name of Provider completing the form.

DATE OF ACT
Record Date of Act as mm/dd/yy. If exact day is unknown, use the month, 1st day of the month (or another default day), year. If exact date of act is unknown, all providers should use the same default day of the month.

HEALTH RECORD NUMBER
Record the patient's health record number.

DOB/AGE
Record Date of Birth as mm/dd/yy and patient's age.

SEX
Indicate Male or Female.

COMMUNITY WHERE ACT OCCURRED
Record the community code or the name, county and state of the community where the act occurred.

EMPLOYMENT STATUS
Indicate patient's employment status, choose one.

RELATIONSHIP STATUS
Indicate patient's relationship status, choose one.

EDUCATION
Select the highest level of education attained and if less than a High School graduate, record the highest grade completed. Choose one.

SUICIDAL BEHAVIOR
Identify the self-destructive act, choose one. Generally, the threshold for reporting should be ideation with intent and plan, or other acts with higher severity, either attempted or completed.

LOCATION OF ACT
Indicate location of act, choose one.

PREVIOUS ATTEMPTS
Indicate number of previous suicide attempts, choose one.

METHOD
Indicate method used. Multiple entries are allowed, check all that apply. Describe methods not listed.

SUBSTANCE USE INVOLVED
If known, indicate which substances the patient was under the influence of at the time of the act. Multiple entries allowed, check all that apply. List drugs not shown.

CONTRIBUTING FACTORS
Multiple entries allowed, check all that apply. List contributing factors not shown.

DISPOSITION
Indicate the type of follow-up planned, if known.

NARRATIVE
Record any other relevant clinical information not included above.