Tennessee Department of Children's Services

Columbia Suicide Severity Rating Scale

Name		TFACTS ID:		DOB	
Facility Name					
Admission Date		Admission Time		☐ AM ☐ PM	

In the past month		
Ask youth the questions that are in bold	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up? Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up	☐	☐
2) Have you actually had any thoughts about killing yourself? General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to Question 6		
3) Have you thought about how you might do this? Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it."	☐	☐
4) Have you had any intention of acting on these thoughts of killing yourself? Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them."	☐	☐
5) Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.	☐	☐
In the past 3 months:		
6) Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	☐	☐

Response Decision Tree – Check the appropriate box to signify level of intervention needed based on youth's responses

☐ "No" to **both** questions 1 and 2 **and** "NO" to Question 6:
No immediate action. Mental health professional will provide routine follow-up assessment.

☐ "Yes" to **either** question 1 or 2 **and** "NO" to questions 3 through 6:
Immediate referral to licensed mental health professional. Assessment by licensed mental health professional to take place within 24 hours.

☐ "Yes" to **any** question 3 through 6:

a. *Immediate referral to licensed mental health professional **and***
b. *Place youth on suicide prevention protocol "Constant Observation" pending assessment with the licensed mental health clinician. Assessment by licensed mental health professional to take place within 24 hours.*

Signature & Title of Screening Staff:_____ Date_____

Time form completed _____ ☐ am ☐ pm