

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	
<input type="checkbox"/>	Part-time
<input type="checkbox"/>	Full-time
<input type="checkbox"/>	Self-employed
<input type="checkbox"/>	Unemployed
<input type="checkbox"/>	Student
<input type="checkbox"/>	Student and employed
<input type="checkbox"/>	Retired
<input type="checkbox"/>	Unknown

Relationship Status	
<input type="checkbox"/>	Single
<input type="checkbox"/>	Married
<input type="checkbox"/>	Divorced/Separated
<input type="checkbox"/>	Widowed
<input type="checkbox"/>	Cohabiting/Common-Law
<input type="checkbox"/>	Same Sex Partnership
<input type="checkbox"/>	Unknown

Education	
<input type="checkbox"/>	High School Graduate/GED
<input type="checkbox"/>	Less than High School, highest grade complete
<input type="checkbox"/>	Some College/Technical
<input type="checkbox"/>	College Graduate
<input type="checkbox"/>	Post Graduate
<input type="checkbox"/>	Unknown

Suicidal Behavior	
<input type="checkbox"/>	Ideation with Plan and Intent
<input type="checkbox"/>	Attempt
<input type="checkbox"/>	Completed Suicide
<input type="checkbox"/>	Att'd Suicide w/ Att'd Homicide
<input type="checkbox"/>	Att'd Suicide w/ Compl Homicide
<input type="checkbox"/>	Compl Suicide w/ Att'd Homicide
<input type="checkbox"/>	Compl Suicide w/ Compl Homicide

Location of Act	
<input type="checkbox"/>	Home or Vicinity
<input type="checkbox"/>	School
<input type="checkbox"/>	Work
<input type="checkbox"/>	Jail/Prison/Detention
<input type="checkbox"/>	Treatment Facility
<input type="checkbox"/>	Medical Facility
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Other (specify):

Previous Attempts	
<input type="checkbox"/>	0
<input type="checkbox"/>	1
<input type="checkbox"/>	2
<input type="checkbox"/>	3 or more
<input type="checkbox"/>	Unknown

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

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

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

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

RPMS Suicide Reporting Form

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.