COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*." ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): 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.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): 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*." ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***"Have you ever 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. **If YES, ask:** ***How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

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Screen Version with Triage Points

II. Reading Hospital Response Protocol to C-SSRS Screening

(Triage points developed by Pumariega and Millsaps)

(Linked to last item answered YES)

Item 1 – Mental Health Referral at discharge
Item 2 – Mental Health Referral at discharge
Item 3 – Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 6 – If over a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition:
- Mental Health Referral at discharge
- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
- Psychiatric Consultation and Patient Safety Monitor/ Procedures