New Jersey Department of Human Services
Division of Mental Health & Addiction Services
Appendix 4: Suicide or Suicide Attempt Questionnaire

Please complete in all cases in which a consumer committed suicide or had a suicide attempt

Consumer Name: ____________________________________ **Incident Date:** _____________ **UIRMS #:** _________________

1) Was the consumer seen by a Designated Screening Center within the last 60 days? ☐ No ☐ Yes If yes, please provide:
   Screening Center Name: ____,

   Screening date: _____________ Disposition (i.e. face-to-face/phone follow-up): ____

   Provide Name of the community mental health service provider(s) and specific program element(s) to which the individual was

   linked at the time of discharge. ____

2) Describe any recent stressors in the consumer's life that could have triggered an increase in psychiatric symptoms, such as: recent hospitalizations, loss of significant other/relationship, loss of job, financial or legal issues, significant medical conditions, loss of and/or change in medications, etc.
   ____
   ____
   ____

   a) What interventions were implemented and what were the outcomes?
      ____
      ____
      ____

3) Did the consumer express any suicidal and/or homicidal ideation? ☐ No ☐ Yes
   a) Did the consumer express any suicide plan or intent? ☐ No ☐ Yes If yes, what interventions were implemented and what were the outcomes (i.e. crisis/safety plan)?
      ____
      ____
      ____

   b) Did the consumer leave a suicide note? ☐ No ☐ Yes If yes, please summarize.
      ____
      ____
      ____

4) Describe any recent or history of suicide attempts, including dates, method and severity of the suicide attempts.
   ____
   ____

   a) Did the consumer require medical treatment and/or inpatient psychiatric treatment? ☐ No ☐ Yes
   b) What interventions were implemented by the community mental health care provider and what were the outcomes?
      ____
      ____
      ____

5) Was a suicide risk assessment completed on the consumer?
   ☐ No Please explain:
   ____
   ____

   ☐ Yes Name/type of assessment tool used: ____

   Date and outcome of the last assessment (please attach):____
   ____

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6) Was the consumer referred to a higher-level, credentialed clinician to assess for suicidality?
☐ No ☐ Yes Name, title, and credentials of the higher-level clinician: ____________________

Date and result of the referral: ____________________

7) Describe any demonstration of recent violent or assaultive behavior.
____
____
____

a) What interventions were implemented and what were the outcomes?
____
____
____

8) Describe how contributing factors such as medications, substance use issues and self-injurious behavior were addressed.
____
____
____

9) What was the consumer's medication (psychiatric and medical – including Medication Assisted Treatment) adherence?
____
____
____

10) How did the agency collaborate with the consumer's primary care physician or specialist?
____
____
____

11) Please, list the consumer's official cause of death (if known).
____
____
____