Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Designated Living Option Suicide Risk Screening/ Assessment

Section A: Screening *Completed by a regulated health care provider within 36 hours of admission to a Designated Living Option, with interRAI assessment/reassessment and when indicated by clinical judgement.*		
1. Does the resident have current suicidal ideation *(e.g. thinking about or planning to end their life)*?	☐ Yes	☐ No
2. Does the resident have a history of suicidal thoughts or previous suicide attempts?	☐ Yes	☐ No
3. Has the resident had a change in mood, behaviours, eating, sleeping or socialization pattern?	☐ Yes	☐ No
4. interRAI Outcome scales show Depression Rating Scale of 5 or greater and Cognitive Performance Scale of 2 or less *(where available)*. *Note: Scores are applicable to all interRAI tools.*	☐ Yes	☐ No

Any yes response to questions 1 to 4 indicates suicide risk assessment is required; complete the remaining sections of the form. If Suicide Risk Assessment is not indicated, stop here and sign that screening has been completed.

Name *(First, Last)*	Signature with Designation
Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Section B: Assessment Completed by a regulated health care provider when indicated by screening or by clinical judgement.		
5. Have you ever wished you were dead?	☐ Yes	☐ No
6. Have you ever thought about ending your life?	☐ Yes	☐ No

If "yes" to questions 5 or 6, proceed through section B; If "no" to both proceed to Section C

7. How often do you have these thoughts? ☐ Daily ☐ Weekly ☐ Monthly

8. Do you have a plan about how you would end your life?
   ☐ Yes, *Specify details* _____
   ☐ No

If "yes" to question 8, complete question 9; If "no" to question 8 proceed to Section C

9. Do you have what you would need to complete your plan?	☐ Yes	☐ No

Section C: Suicide Risk Factors

10. Have you attempted to end your life before?
    ☐ Yes, when? ☐ Within the past 3 months ☐ More than 3 months ago ☐ Other _____
    ☐ No

11. Have there been any suicides or attempts among family or friends?	☐ Yes	☐ No

12. Have you ever been diagnosed with a mental illness?
    ☐ Yes, *Specify diagnosis* _____
    How do you feel about that diagnosis? _____
    ☐ No

Name *(First, Last)*	Signature with Designation
Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

Alberta Health Services

Designated Living Option Suicide Risk Screening/ Assessment

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Section C: Suicide Risk Factors Continued

13. Are you experiencing any of the following *(check all that apply)*

- ☐ Increased or excessive substance use
- ☐ Feeling as if you are a burden
- ☐ Anger, anxiety or agitation
- ☐ Feeling trapped
- ☐ Lack of interest or energy
- ☐ Feeling overwhelmed
- ☐ Loss of independence/functional ability or loss of loved ones
- ☐ Changes in cognition/memory
- ☐ Withdrawal from friends, family or society
- ☐ Feelings of hopelessness/helplessness
- ☐ Feeling isolated
- ☐ Mood changes
- ☐ Lack of purpose
- ☐ Sleep disturbance
- ☐ Unmanaged health concerns, illness or aging changes
- ☐ Chronic pain or increase in physical pain

Section D: Protective Factors

14. Who do you turn to for support? *(E.g., people, pets, services)*

15. How have you gotten through tough times previously?

16. What are some things you can do to help keep yourself safe or support mental well-being?

Section E: Action Items

Identified by a regulated health care provider applying clinical judgement in the context of the situation. Refer to the Designated Living Options Suicide Risk Resource Guide for additional information.

Suicide Risk is considered to be *(select one)* ☐ Low ☐ Moderate ☐ High/Imminent

Management Strategies *(select all that apply)*. Document details in resident health record.

- ☐ Consult with Most Responsible Health Provider (MRHP)
- ☐ Notify others as applicable e.g., family, AHS Case Manager, Unit Manager, etc.
- ☐ Implement/review interventions/strategies in the resident's care plan
- ☐ Review interventions/strategies at care conference
- ☐ Consult/refer to other health care professional(s) or programs when clinically indicated
- ☐ Use Outcome Scales Report to track changes
- ☐ Monitor for signs of suicide risk
- ☐ Transfer to appropriate facility/unit or higher level of care
- ☐ Other _____

Resident Monitoring Frequency *(select one)*

- ☐ Hourly
- ☐ Every 2 hours
- ☐ Every 4 hours
- ☐ Site/unit routine _____
- ☐ Constant/1:1 *(ordered by MRHP)*
- ☐ Other _____

Name *(First, Last)*	Signature with Designation
Date *(dd-Mon-yyyy)*	Time *(hh:mm)*