asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ☒ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ☒ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ☒ No
4. **Have you ever tried to kill yourself?** ☒ Yes ❍ No

If yes, how? I took sleeping and anxiety pills with alcohol

When? 2-years ago in December

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ☒ No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741