

Suicide Threat/Attempt Report Form

Student's Name: _____ Date/Time: _____

Name of person making initial referral: _____

School Counselor/Principal involved: _____

Student interviewed by: _____

Assessment (circle one):

No Risk

Moderate Risk

Severe Risk

Extreme Risk

Comments:

Parent/Guardian Person contacted: _____

Parent contact made by: _____ Date/Time: _____

Comments:

Organization/Professionals contacted: _____

Follow-up comments:

(Documentation directions)
Suicide Threat/Attempt Report Form

Student's Name: _____ Date/Time: _____

Name of person making initial referral: _____
(Name of person who first heard threat or saw attempt)

School Counselor/Principal involved: _____
(List both)

Student interviewed by: _____
(Name of FCS employee who assessed student)

Assessment (circle one):

(Assessment based on FCS policy)

No Risk

Moderate

Severe Risk

Extreme Risk

Comments:

Parent/Guardian Person contacted: _____

Parent contact made by: _____ Date/Time: _____

Comments:

Organization/Professionals contacted: _____
(Resource that was contacted after initial assessment, ie: FRC, Century Health, other Behavioral Health organization or CPS)

Follow-up comments: