



At the request of the National Institute of Health, our Practice has been ask to test a new instrument designed to screen for suicidal risk in our adolescent patients. The screening questionnaire has been tested and validated in the Emergency Room setting but never in a private pediatric office.

We have agreed to do this project because of the alarming statistics on the rate of suicide in our countries adolescent population. As we are sure you know, above all, our office really wants to keep all of our patients healthy, both mentally and physically and to keep them safe.

During today's visit our nurse, trained by the National Institute of Mental Health on suicide screening and risk assessment, will ask your child some questions in private. These additional questions ask about depression and suicide risk, which are major public health problems for youth in the United States.

If we have any concerns after asking the screening questions, we will let you know. We will also ask your opinion about our new process, and hope you will give us feedback.

Please note that no identifying information about you or your child will be sent to the NIMH. All personally identifying information will be kept confidential, only shared with your child's doctor.

And as always, please feel free to ask your child's doctor if you have any questions, or concerns, about our quality improvement efforts in such an important area.

Time to complete ASQ: _____

Age: _____ yrs

Race: _____

Gender: _____



Ask Suicide-Screening Questions

Suicide Screening Questions for the Primary Care Clinic

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?

When?

If the patient answers yes to any of the above...

5. Are you having thoughts of killing yourself right now?

Yes No

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For parents/guardians of children 12 years or older

Our office is trying a new initiative to screen our patients for suicide risk. Your child was screened today. As part of our continuous quality improvement efforts, we would appreciate it if you would take the time to answer the following questions. Please do not write your name on this form.

1. What is your relationship to the child?

- Mother Father Grandmother Grandfather
 Legal guardian Other (please specify) _____

2. Do you think nurses should ask kids about suicidal thoughts when they are at the doctor's office?

- Yes No I don't know

Why / why not?

3. How comfortable are you with health care professionals screening your child for suicide risk?

- Very comfortable
 Somewhat comfortable
 Neutral
 Somewhat uncomfortable
 Very uncomfortable

Can you explain why you feel this way? _____

4. Do you think you would know if your child was thinking about suicide?

- Yes No I don't know/Not sure

5. Do you have any concerns about your child being screened for suicide risk during a medical visit?

- Yes No

If yes, what are they? If no, any other comment would be greatly appreciated:

Thank you! Your feedback is greatly appreciated!

FOR OFFICE USE ONLY:

- ASQ POSITIVE ASQ NEGATIVE