**Calloway County Schools**

 **Suicide Risk Assessment Referral Data**

Referral Date: \_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

**Student’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Lives With: A. \_\_\_ Both Parents B. \_\_\_Mother C. \_\_\_Father D. \_\_\_Other Guardian

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Educational Program**:

A. \_\_\_Regular B. \_\_\_Special Education C. \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_

Bilingual Status: A. \_\_\_Non-English Speaking B. \_\_\_English Only

**Student Referred By**: (Check one or more)

1. \_\_\_Self D. \_\_\_Counselor G. \_\_\_Student/Friend
2. \_\_\_Parent E. \_\_\_School Psychologist H. \_\_\_Administrator
3. \_\_\_Teacher F. \_\_\_Nurse I. \_\_\_Other (Specify) \_\_\_\_\_

**Reason For Referral**: (Check one or more)

1. \_\_\_Indirect Threat G. \_\_\_Signs of Depression
2. \_\_\_Direct Threat H \_\_\_ Truancy or Running Away
3. \_\_\_Previous Attempt(s) Indicated I. \_\_\_Frequent Complaints of Illness
4. \_\_\_Giving Away Prized Possessions J. \_\_\_ Drug or Alcohol Abuse
5. \_\_\_Mood Swings K. \_\_\_Other (Specify) \_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_Sudden Changes of Behavior L. \_\_\_Current Attempt

**Previous Suicide Risk Assessment Referral**: \_\_\_No \_\_\_Yes

**Data Recorded by School Personnel**:

1. \_\_\_Counselor C. \_\_\_Nurse E. \_\_\_Other (specify)
2. \_\_\_School Psychologist D. \_\_\_Administrator \_\_\_\_\_\_\_\_\_\_\_

**Interventions/Outcomes(s)**: (Check Where Appropriate)

1. \_\_\_Parent Contact Made G. \_\_\_School Support Strategies
2. \_\_\_Information/Handout Provided H. \_\_\_Individual Counseling
3. \_\_\_Referral To Community Agency J. \_\_\_Group Counseling
4. \_\_\_Protective Services Notified K. \_\_\_Program Modification
5. \_\_\_Hospitalization L. \_\_\_Other (Specify) \_\_\_\_\_\_\_\_\_\_
6. \_\_\_Community Resources Provided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Postvention Contacts** | **Date** | **Date** | **Made by** |
| Two weeks following initial contact |  |  |  |
| One month following initial contact |  |  |  |
| Two months following initial contact |  |  |  |
| Three months following initial contact |  |  |  |
| Contact CHFS/Protective Services |  |  |  |