BEACON Specialized Living

Referral Packet

Please send referrals back to:
referrals@beaconspecialized.org or
fax to (866) 407-0531

Due to the high volume of referrals that Beacon Specialized Living receives, we ask that once a client has been accepted to our program that CMH/guardian have appropriate paperwork completed and signed within 5 business days. This will ensure our process can continue to operate efficiently and we can continue to provide the most expedient placements for your clients. If completed paperwork is not able to be received within 5 business days, Beacon will have to proceed with the next referral in line as we DO NOT promise a bed hold.

Attached in our Referral Packet is our Service Authorization Form, regarding services that will be authorized at time of placement. This must be signed by all parties.

Beacon DOES NOT bill Medicare/Medicaid, and this will ensure no payment issues upon placement for such services as Psychiatric, Case Management, Therapy, etc. Beacon will expect payment for those services authorized and indicated by the CMH representative signature on the above said form.

If you have any questions, you can also email our referral department at referrals@beaconspecialized.org or you may contact our corporate office by calling (269) 427-8400 and asking to speak to a member of our referrals team.

CONFIDENTIAL

Persons completing this document and the persons receiving the disclosed information may only further disclose consistent with the authorized purpose for which it is intended or disclosed (MH 1748-[3]).

***** Please note that Beacon Specialized Living is HCBS compliant. To ensure that we remain compliant, any restrictions to food, community access or other items adults would normally have in their own home must be indicated in a behavior plan.***

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Service Authorization Form

Who is requesting services:

- ☐ Manager
- ☐ Nurse
- ☐ Clinician
- ☐ Intake

Services requested:

- ☐ Therapy
- ☐ Enhanced Staffing/One-on-One
- ☐ Transportation
- ☐ Behavior Plan
- ☐ Behavior Plan Monitoring Case
- ☐ Management Psychiatric—Med
- ☐ Review Psychiatric—Psych
- ☐ Evaluation

Costs related to service: _____

Communication of requests:

Date	Initials	Action	Comments

Beacon representative: _____ Date:_____
CMH Representative: _____ Date:_____
Guardian:_____ Date: _____
(if applicable)

BSLS does not bill Medicaid/Medicare. Therefore, your signature represents authorization of said services and in turn BSLS will expect payment from your agency, regardless of whether or not you are the "payor of last resort".

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Please answer the following questions related to the consumer:

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ SSN: _____ Gender: _____

Marital Status: _____ Race: _____

Client Reference #: _____ Height: _____ Weight: _____

Client Code: _____ Beacon Reporting Cost Center Code (CEI Referral Only) _____

Veteran: Yes ☐ No ☐ Is there a surviving spouse/child of veteran? ☐ Yes ☐ No

Primary Language: _____ Date of Referral: _____

COVID-19 Vaccination Status:

Fully vaccinated ☐ Partially vaccinated ☐ Unvaccinated ☐ Received Booster ☐

Court Order: ☐ Yes ☐ No Type (If applicable)/Please Attach Current Court Order: _____

Expires: _____

County In Which Order Was Issued: _____

Is there a specific home to which you are referring the individual?
If yes, which home(s) or geographic areas is the individual interested in:

_____

_____

Are there any areas of the state to which you would prefer the individual not be referred (ie: Eastside, certain towns, Upper Peninsula, etc.)? ☐ Yes ☐ No

_____

_____

Funeral Provisions & Preferences: _____

Religious Preference: _____

Current Address: _____ City, St, Zip _____

Contact Name: _____ Contact phone number: _____

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REFERRAL SOURCE CONTACT

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

PHYSICIAN

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *(FAX):* _____

PSYCHIATRIST

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *(FAX):* _____

RESPONSIBLE AGENCY

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *(FAX):* _____

CASE MANAGER

Name: _____ Email: _____

Address: _____ City, St, Zip: _____

Phone: *(CELL)* _____ *FAX):* _____

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EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

NEXT OF KIN

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

GUARDIAN

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

PAYEE/CONSERVATOR

Name: _____ Relationship: _____

Address: _____ City, St, Zip: _____

Email: _____ Phone: *(CELL)* _____ *(FAX)* _____

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Diagnosis:

Diet:

Diet Order:

*If client does have a diet order, please send to the Beacon referral team.

Does the Client Need Assistance with Eating? ☐ Yes ☐ No

If so, What Type of Staff Supervision is Needed? _____

Allergies: _____

Contracted Services:

☐ Case Management
☐ Group Counseling
☐ Enhanced Staffing: (# of hours) _____
☐ Behavior Treatment Plan
☐ Individual Counseling
☐ Behavior Plan Monitoring: _____
☐ Psychiatric Services
☐ Dialectical Behavior Therapy

Medications: (current medications. Please list below or attach a list)

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ADVANCED DIRECTIVES

Does individual have an advanced directive? ☐ Yes ☐ No

If yes, attach a copy.

Is there a psychiatric advanced directive? ☐ Yes ☐ No
If yes, attach a copy.

Will Beacon staff need to assist individual in applying for benefits? ☐ Yes ☐ No

Does the individual currently have Medicaid and/or Social Security benefits? If yes, please include policy number and types of policies. ☐ Yes ☐ No

Policy Number: _____ Types of Policies: _____

MEDICAID: Number/Plan: _____

Spend down? If yes, amount: _____ ☐ Yes ☐ No

MEDICARE: Part A: _____

Part B: _____

Part C: _____

Part D: _____

Medicare Advantage Plan: _____

Private Insurance (Name of Plan & ID Number): _____

Does individual have current insurance cards (not copies)? ☐ Yes ☐ No
Please attach copy if possible.

If no, can physical cards be requested? ☐ Yes ☐ No

Does individual receive Supplemental Security Income? ☐ Yes ☐ No

If yes, how much do they receive a month?: _____

Does individual have a valid state ID? ☐ Yes ☐ No

Is individual under 26 years of age? ☐ Yes ☐ No

If yes, would they be interested in the School Program? ☐ Yes ☐ No

Current Individualized Education Program? ☐ Yes ☐ No

Please attach copy or list last known school attended: _____

Is individual a diabetic? ☐ Yes ☐ No

If yes, does individual have a guardian? ☐ Yes ☐ No

If applicable, does individual have doctor's permission to administer their own insulin? ☐ Yes ☐ No

Are there any medication compliance issues? ☐ Yes ☐ No

Please explain:

_____

_____

_____

Does the Resident have swallowing issues or at risk for choking?

If yes, when was the last swallow study completed? _____

(Please attach the most recent study completed to this referral packet)

Are there any other eating disorders that we should be aware of?
If yes, what are they? _____

(PLEASE NOTE: If any of the above are a concern due to living in the home where there is access to food/drinks, a behavior plan will need to be implemented.)

Is the individual a suicide risk? ☐ Yes ☐ No
Please explain:

_____

_____

_____

Is the individual a threat or danger to others and/or do they have thoughts to harm others? Please explain. ☐ Yes ☐ No

_____

_____

_____

Does this individual have a history of sexual inappropriateness or sexually assaultive behaviors? Please explain: ☐ Yes ☐ No

Has the individual had any recent threatening behavior? Please explain: ☐ Yes ☐ No

Are there any high-risk behaviors (ie: cutting, head banging, elopement, self-injurious behavior, poor or dangerous relationships, risk taking, etc.)? Please explain: ☐ Yes ☐ No

Does the individual appear to be compatible with other individuals in the home? Are there any foreseeable problems? Has the individual agreed to having a roommate as required by HCBS if applicable? Please explain: ☐ Yes ☐ No

Does the client need to be registered with police referencing public indecency and/or a sex offense? If so, how often do they need to register? Please describe the nature and date of the offense. ☐ Yes ☐ No

Has the individual agreed to live in a Beacon home (as required by HCBS)? Please explain: ☐ Yes ☐ No

Does the individual require continuous nursing care? Please explain: ☐ Yes ☐ No

Does the individual require isolation for medical purposes? Please explain: ☐ Yes ☐ No

Does the individual have any medical diagnosis that require a specialist care or that would make them potentially high-risk and require extra briefing of the staff? Please explain: ☐ Yes ☐ No

Does the individual require seclusion or a restraint? Please explain: ☐ Yes ☐ No

Does the individual want to participate in any social and/or programmed activities? ie: school, workshop/job, religious practices, etc. ☐Yes ☐No
Please explain:

What amount of personal care does the individual need? Please write in the amount of personal care the referral source indicates the individual needs with an explanation of the type.
Please explain:

What amount of supervision does this individual need? ie: Does the client need one-on-one supervision in the house or in the community? Please be as detailed as possible as to how many hours if one-on-one is being requested. (Please note if the client has restricted community access, this must be in a Behavior Plan upon arrival at the facility.) Please explain:

What amount of protection does this individual need? Include whether the individual has a high potential of being a victim of abuse.

What kind of skills does the home need available to meet this individual's needs? ie: nurse, social worker, therapist, gentle teaching, etc.

What kind of physical accommodations does the home need to be able to meet the individual's needs? ie: alarms, fence, staffing levels, handicap accessibility, etc.

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Please attach the following required documents if available:

- Guardianship Paperwork
- Health Care Appraisal
- Current Psychiatric Evaluation
- Any Psychological Assessments
- Upcoming Medical/Dental Appointments
- Clinical Certifications
- Treatment Orders
- Current Medication List/Current Prescriptions
- Current Person Centered Plan
- Behavior Plan, if applicable

Note: If individual is to be placed behind a fence, a Behavior Plan is required upon admission. Additionally, if individual has behaviors that Beacon determines require a Behavior Plan to keep them safe, we may require this to be in place upon the date of admission.

COMMUNITY ACCESS

Will this individual have independent community access at the time of intake? ☐Yes ☐No

If yes, how many hours per day/week will individual be able to access the community?

_____

_____

_____

_____

If the client does not have community access or has limitations on community access, they must arrive with a plan clearly outlining the restriction. Otherwise they are presumed to have full unrestricted access. Marking "no" on the referral is not enough for Beacon to restrict an individual's freedom of movement.

Beacon Specialized Living Services, Inc. community access guidelines:

- The resident must sign in and sign out with facility staff upon leaving and returning from community access.
- The organization is not responsible for transportation to or from community access.
- The resident is responsible for being present for all medication passes.
- Resident to staff ratio will be maintained and elopement policies will be followed identically to facility policies unless otherwise indicated in the individual's plan.
- Staff will maintain routine checks during supervised community outings, unless stated otherwise in individual's plan.

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Risk Assessment (Lifeline crisis center version)

NATIONAL SUICIDE PREVENTION LIFELINE

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Columbia-Suicide Severity Rating Scale (C-SSRS)

The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is a questionnaire used for suicide assessment developed by multiple institutions, including Columbia University, with NIMH support. The scale is evidence-supported and is part of a national and international public health initiative involving the assessment of suicidality. Available in 103 different languages, the scale has been successfully implemented across many settings, including schools, college campuses, military, fire departments, the justice system, primary care and for scientific research.

Several versions of the C-CCRS have been developed for clinical practice. The **Risk Assessment** version is three pages long, with the initial page focusing on a checklist of all risk and protective factors that may apply. This page is designed to be completed following the client (caller) interview. The next two pages make up the formal assessment. The C-SSRS Risk Assessment is intended to help establish a person's immediate risk of suicide and is used in acute care settings.

In order to make the C-SSRS Risk Assessment available to all Lifeline centers, the Lifeline collaborated with Kelly Posner, Ph.D., Director at the Center for Suicide Risk Assessment at Columbia University/New York State Psychiatric Institute to slightly adjust the first checklist page to meet the Lifeline's Risk Assessment Standards. The following components were added: helplessness, feeling trapped, and engaged with phone worker.

The approved version of the C-SSRS Risk Assessment follows. This is one recommended option to consider as a risk assessment tool for your center. If applied, it is intended to be followed exactly according to the instructions and cannot be altered.

Training is available and recommended (though not required for clinical or center practice) before administering the C-SSRS. Training can be administered through a 30-minute interactive slide presentation followed by a question-answer session or using a DVD of the presentation. Those completing the training are then certified to administer the C-SSRS and can receive a certificate, which is valid for two years.

To complete the C-SSRS Training for Clinical Practice, visit http://c-ssrs.trainingcampus.net/

For more general information, go to http://cssrs.columbia.edu/

Any other related questions, contact Gillian Murphy at gmurphy@mhaofnyc.org.

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injury Behavior (Past week)		**Clinical Status (Recent)**	
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Helplessness*
☐	Aborted attempt ☐ Lifetime	☐	Feeling Trapped*
☐	Other preparatory acts to kill self ☐ Lifetime	☐	Major depressive episode
☐	Self-injury behavior w/o suicide intent ☐ Lifetime	☐	Mixed affective episode
Suicide Ideation (Most Severe in Past Week)		☐	Command hallucinations to hurt self
☐	Wish to be dead	☐	Highly impulsive behavior
☐	Suicidal thoughts	☐	Substance abuse or dependence
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Agitation or severe anxiety
☐	Suicidal intent (without specific plan)	☐	Perceived burden on family or others
☐	Suicidal intent with specific plan	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
Activating Events (Recent)		☐	Homicidal ideation
☐	Recent loss or other significant negative event	☐	Aggressive behavior towards others
	Describe:	☐	Method for suicide available (gun, pills, etc.)
		☐	Refuses or feels unable to agree to safety plan
☐	Pending incarceration or homelessness	☐	Sexual abuse (lifetime)
☐	Current or pending isolation or feeling alone	☐	Family history of suicide (lifetime)
Treatment History		**Protective Factors (Recent)**	
☐	Previous psychiatric diagnoses and treatments	☐	Identifies reasons for living
☐	Hopeless or dissatisfied with treatment	☐	Responsibility to family or others; living with family
☐	Noncompliant with treatment	☐	Supportive social network or family
☐	Not receiving treatment	☐	Fear of death or dying due to pain and suffering
Other Risk Factors		☐	Belief that suicide is immoral, high spirituality
☐		☐	Engaged in work or school
		☐	Engaged with Phone Worker *
		Other Protective Factors	
		☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

	Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	Yes ☐ No ☐	Yes ☐ No ☐

INTENSITY OF IDEATION

	Most Severe	Most Severe
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. <u>Lifetime</u> - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** <u>Recent</u> - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***		
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____	**Yes** ☐ **No** ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) _____ x 0 =	_____
Several days	(#) _____ x 1 =	_____
More than half the days	(#) _____ x 2 =	_____
Nearly every day	(#) _____ x 3 =	_____

Total score: **_____**

Interpreting PHQ-9 Scores

Minimal depression	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Actions Based on PH9 Score

Score	Action
< 4	The score suggests the patient may not need depression treatment
> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/