This is a note template used by our clinicians when seeing students referred by the SOS program. It contains a mix of drop-down menus and space for clinicians to free text answers.

Rush Community Based Practices
Behavioral Health Visit Note - Success Over Stress

Visit Type: ☒Walk-In ☒ Success over Stress referral for further screening ☐ Integrated Visit (Integrated visit occurred in the context of a medical visit, referred to BH by medical provider) ☐ Initial Evaluation ☐Follow-Up ☐ Case management ☐ Telehealth ☐ Bright Futures

11/23/2022
Start Time: **[Insert Time]**
End Time: **[Insert Time]**
Total Time spent with patient: **[Insert number]** minutes

Presenting Problem: **[insert text]**[Patient Name] is a [Age] [Gender] referred for a suicide risk assessment by the Success over Stress research team after screening positive on their risk assessment earlier today.

History obtained from: patient. Past medical records **[have]** or **[have not]** been reviewed. Patient minor consent for treatment on file. Discussed confidentiality within the integrated team and mandated reporter status. Patient verbalized understanding.

All fields except for mood have drop downs for clinicians to select appropriate answers

MENTAL STATUS EXAM
Appearance:
Behavior/Motor:
Level of consciousness:
Attitude toward examiner:
Speech/language:
Mood: **[insert text]**
Affect:
Thought processes:
Thought content:
Concentration: (observed)
Memory: (observed)
Fund of knowledge:
Insight:
Judgment:

PHQ-9 Auto populates from built-in questionnaire. Students are typically asked to complete PHQ-9 upon arrival on paper, and clinician reviews it with patient

PHQ-9 QUESTIONNAIRE

PHQ-2/9 Depression Screen	11/23/2022
Little interest or pleasure in doing things	0 - not at all
Feeling down, depressed, or hopeless	0 - not at all
Trouble falling asleep, staying asleep, or sleeping too much	3 - nearly every day
Feeling tired or having little energy	1 - several days
Poor appetite or overeating	2 - more than half the days
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	1 - several days
Trouble concentrating on things, such as reading the newspaper or watching television	1 - several days
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0 - not at all
Thoughts that you would be better off dead, or of hurting yourself in some way	1 - several days
PHQ-2 total:	0
Depression screen total:	9
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

The Columbia suicide Assessment build into this note contains seven questions with drop down lists, listed here as bulleted lists. It also contains a section at the end to describe or elaborate on any parasuicidal or aggressive behavior

COLUMBIA SUICIDE ASSESSMENT

Suicidal and Self-Injurious Behavior, Past 3 Months:

- Actual Suicide Attempt
- Interrupted Attempt
- Aborted or Self-Interrupted Attempt
- Other preparatory acts to kill self
- Self-injurious behavior without suicidal intent
- No suicidal or self-injurious behavior

Suicidal and Self-Injurious Behavior, Lifetime:

- Actual Suicide Attempt
- Interrupted Attempt
- Aborted or Self-Interrupted Attempt

- Other preparatory acts to kill self
- Self-injurious behavior without suicidal intent
- No suicidal or self-injurious behavior

Suicidal Ideation, Most Severe in Past Month:
- No suicidal ideation
- Wish to be dead
- Thoughts about suicide
- Suicidal thoughts with method (but without specific plan or intent to act)
- Suicidal intent (without specific plan)
- Suicidal intent with specific plan

Recent Activating Events:
- None
- Recent loss(es)
- other significant negative event(s) (legal, financial, relationship, etc.). Describe: **[insert text]**
- Pending incarceration or homelessness
- Current or pending isolation or feeling alone

Treatment History:
- Previous psychiatric diagnoses and treatments
- Hopeless or dissatisfied with treatment
- Non-compliant with treatment
- Not receiving treatment
- No previous treatment

Recent Clinical Status:
- Hopelessness
- Major depressive episode
- Mixed affective episode (e.g. Bipolar)
- Command hallucinations to hurt self
- Highly impulsive behavior
- Substance abuse or dependence
- Agitation or severe anxiety
- Perceived burden on family or others
- Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.) Homicidal ideation
- Aggressive behavior towards others
- Method(s) for suicide available: **[insert text]**
- Refuses or feels unable to agree to safety plan
- Sexual abuse (lifetime), Family history of suicide (lifetime)
- Other Risk Factors: **[insert text]**
- None. Standard clinical risk factors were reviewed and none were present.

Protective Factors:
- None. Standard protective factors were reviewed and none were present
- Identifies reasons for living
- Responsibility to family or others

- living with family
- Supportive social network or family
- Fear of death or dying due to pain and suffering
- Belief that suicide is immoral
- high spirituality
- Engaged in work or school
- Other Protective Factors: **[insert text]**

Describe any suicidal, self-injurious or aggressive behavior (include dates): **[insert text]**

The Assessment and Treatment Plan contain the clinician's clinical judgement, as well an appropriate follow-up plan.

ASSESSMENT AND TREATMENT PLAN

Diagnosis: **Suicidal ideation**

Impression: **[insert text]** experienced suicidal thoughts as recently as **[insert text]** ago. There are significant limits to the prediction of dangerousness, including confounding issues of magnitude, likelihood, imminence, frequency and causation. While involuntary hospitalization or restraint may sometimes be necessary, such interventions carry paradoxical risks, such as decreasing a patient's likelihood for voluntarily seeking out future medical care. The patient engaged in coping skills while experiencing recent suicidal thoughts. The patient denies any current suicidal thoughts and reports feeling safe at this time. Thus, at this time, there are no acute safety risks that require escalation to a higher level of care.

Intervention: Suicide risk assessment, created safety plan.
Reviewed the gravity of suicidal gestures with patient and provided guidance as to when seeking mental health treatment may be beneficial.
Provided contact information for CARES line/SASS 1800 345-9049 if this occurs in the future.
Advised patient to call 911 or visit the emergency department with any future thoughts of suicidal or homicidal ideation.
Patient confirmed that they have the phone number for the National Suicide Hotline saved in their phone.
[insert text] Guardian contacted via phone and notified of safety concerns.
[insert text] safety plan which included taking a time out or break