

Adolescent Suicide Attempt Report

1. Name of hospital: _____ County: _____
2. Date of attempt (Month/Day/Year): ____/____/____
3. Admitted as an in-patient? Yes No Transferred to another hospital (Specify): _____
4. Patient or hospital chart number: _____
5. Date of birth (Month/Day/Year): ____/____/____
6. Sex: Male Female
7. Race: White Black Am. Indian Other (Specify): _____
8. Hispanic: Yes No
9. Residence City: _____ County: _____
10. Patient lives with:
 - Both parents Parent and stepparent Father only Mother only Foster parents
 - Juvenile facility Friends Homeless Unknown Other (Specify): _____
11. Place of attempt:
 - Own home Other home Foster home School Juvenile facility Other (Specify): _____
12. Method or methods used in attempt:
 - Poisoning by solid or liquid substance including drug or alcohol overdoses, and other potentially toxic substances – Specify substance(s): _____
 - Hanging or suffocation – Specify method: _____
 - Firearms and explosives – Specify type (hand gun, rifle, etc.) and body site: _____
 - Cutting or piercing – Specify instrument and body site: _____
 - Other means such as motor vehicle crash, drowning, fire, etc. – Specify: _____
13. History of mental health issues:
 - Major depression Dysthymia Bipolar disorder ADHD or ADD Adjustment disorder
 - Conduct disorder PTSD Eating disorder Other (Specify): _____ None Unk.
14. Number of previous suicide attempts made during lifetime:
 - 0 1 2 3 4 5 6+ Attempts made, but unknown History unknown
15. Precipitating events and risk factors:
 - Family discord Argument or breakup with boyfriend/girlfriend Peer pressure/argument
 - School problems Suicide or attempt by friend/relative Pregnancy
 - Death of friend/relative Move or new school None
 - Physical abuse – Specify type and perpetrator, if known: _____
 - Sexual abuse or rape – Specify type and perpetrator, if known: _____
 - Alcohol and/or drug abuse – Specify substance(s): _____
 - Prior arrests and/or convictions of a crime – Specify: _____
 - Other – Specify: _____
16. Did the youth tell others of his or her plan to attempt/commit suicide? Yes No Unknown
 - If yes, whom did the youth tell? Parent Friend Teacher Other (Specify): _____
17. Was the youth referred for intervention? No Yes – Specify to whom: _____
18. Name of person completing report (Print): _____ Dept.: _____

SAMPLE

ORS 441.750 states that

“Any hospital which treats as a patient a person under 18 years of age because the person has attempted to commit suicide: Shall cause that person to be provided with information and referral to in-patient or out-patient community resources, crisis intervention or other appropriate intervention by the patient’s attending physician, hospital social work staff or other appropriate staff.” and “Shall report statistical information to the Department of Human Services about the person. . . .”



Mail this form no later than the 15th of the month following the month of the attempt to: **Center for Health Statistics**

Telephone: 503-731-4474

Fax: 503-731-3076

P.O. Box 14050

Portland, Oregon 97293-0050