

## Adolescent Suicide Attempt Report Zero Attempts

1. Name of hospital \_\_\_\_\_
2. Hospital county \_\_\_\_\_
3. During (Month/Year) \_\_\_\_\_ / \_\_\_\_\_, no youth 17 or younger was treated here for a suicide attempt.

*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 report statistical information to the Department of Human Services about that person. . . ."*

<b>Contact Person at this Facility</b> <i>Please print</i>	
Name	_____
Title	_____
Department	_____
Telephone	_____

*Mail this form to the address below no later than the 15th of the month following any month in which there were no youths treated at your hospital for a suicide attempt.*

Adolescent Suicide Attempt Data System  
Center for Health Statistics  
P.O. Box 14050  
Portland, Oregon 97293-0050

Telephone: 503-731-4474  
Fax: 503-731-3076