

SCREENING FOR SELF / OTHER DIRECTED HARM

Instructions: Please check 'yes' or 'no' for each question.

(Constant Observation)

- | | | |
|---|------------------------------|-----------------------------|
| Was there a potentially lethal suicide attempt in the past 24 hours? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there statements of intent to self-harm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there a plan for self-harm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the patient unwilling and unable to contract NOT to harm oneself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the patient experiencing auditory hallucinations that command self-harm? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Actual physical harm to others | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Threats of physical harm to others | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Destruction of Property | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

A YES on any of the above questions dictates the need for 1-to-1 observation

Placed on 1-to-1 observation precautions as indicated. Yes No N/A

Physician contacted _____ Date / Time _____

Precaution level ordered by physician 1-to-1 Line of Sight Q15 Min.

Nurse Signature

Date

Time

AM/PM



Patient Label