Suicide Precautions Initial Treatment Plan

[not recommended for use if placed in ACU or CSU]

Identification

Facility: _____
Offender: _____
GDC ID#: _____
DOB: _____
Race: _____ **Sex:** _____

Date initiated: _____

Problem: **[ ] Environmental / Contextual Factors**

[ ] Suicide Risk Factors
Specify: _____
_____
_____

[ ] Self Injurious Behavior
Specify: _____

[ ] Suicide Attempt
Specify: _____

Goal:
(a) Physical Safety
(b) Decrease in suicide risk factors
(c) Increase in protective factors / level of care
(d) Return to daily routine/activities

Revisions should be made to the comprehensive treatment plan's goals and interventions.

Clinical Interventions:

[ ] Individual Counseling
starting date: _____ frequency: _____
person responsible: _____

[ ] Placement in Suicide Prevention Group
starting date: _____ person responsible: _____

[ ] Activity Therapy
specify: _____ frequency: _____
person responsible: _____

[ ] Psychotropic Medication (change or addition)
specify: _____ person responsible: _____

_____	_____	_____	_____
Offender's/Detainee's Signature	**Date**	**MH Counselor's Name (Print)**	**Signature**	**Date**

Reviewed by:

_____	_____	_____	_____
Upper Level Provider's Name (Print)	**Signature**	**Title**	**Date**

Retention Schedule: Completed forms shall be placed in the offender's mental health file (section 2). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.