FAR WEST FAMILY SERVICES

Employee Assistance Program

SUICIDE/ HOMICIDE RISK ASSESSMENT

CLIENT NAME: _____

EMPLOYER: _____

THERAPIST: _____

1. CURRENT BEHAVIOR:
   - ❑ DENIES
   - ❑ IDEATION
   - ❑ THREAT
   - ❑ ATTEMPT

2. PLAN:
   - ❑ NO PLAN
   - ❑ VAGUE PLAN
   - ❑ EXPLICIT PLAN

3. AVAILABLE MEANS:
   - ❑ NONE
   - ❑ EASILY
   - ❑ IN POSSESSION

4. PRIOR BEHAVIOR:
   - ❑ NONE
   - ❑ ONE
   - ❑ MULTIPLE
   - ❑ FRIEND/FAMILY

5. TIME SINCE LAST ATTEMPT:
   - ❑ DENIES PRIOR ATTEMPTS
   - ❑ 1 MONTH OR LESS
   - ❑ 1-3 MONTHS
   - ❑ 3-6 MONTHS
   - ❑ 6-12 MONTHS
   - ❑ 12+ MONTHS

6. SUICIDE CONTRACT ON FILE
   ☐ NO ☐ YES, DATE _____

7. HOMICIDE CONTRACT ON FILE
   ☐ NO ☐ YES, DATE _____

COMMENTS/NOTIFICATIONS (IF APPLICABLE):

_____

_____

_____

_____

_____

_____

_____

THERAPIST'S SIGNATURE: _____ DATE _____

PLEASE SUBMIT TO THE FAR WEST OFFICE *IMMEDIATELY* BY FAX (206.363.4614)
OR MAIL TO PO BOX 33788, SEATTLE, WA 98133