C-SSRS Documentation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

The C-SSRS classifies suicidal ideation and behavior into defined categories; it produces no summed score, and a screen is not an assessment. Defensible documentation shows the chain a surveyor traces: exact version, category-level result, same-visit assessment for positives, an overall risk formulation with reasoning, completed actions, and owned follow-up.

Exact version and circumstances "C-SSRS done" is not a result

Do: name the version (Screener Recent, full Lifetime/Recent, Since Last Contact), timeframe, mode, date/time, administrator role.
Pitfall: versions measure different timeframes; an unnamed version cannot be traced or compared.

Category-level result never a bare number or color

Do: record highest ideation category, behavior category or none, recency, and positive/negative under the named local protocol.
Pitfall: "score 4" is ambiguous four ways; "red" documents the wall chart, not the patient.

Branching fidelity validity lives in the flow

Do: note that all applicable branches were completed; record participation limits.
Pitfall: partial administration read as a negative result.

Screen-to-assessment chain the most-cited survey finding

Do: follow a positive screen with a same-visit evidence-based assessment: ideation, plan, intent, behavior, risk and protective factors.
Pitfall: the screen standing in for the assessment, or a negative screen closing a concern the interview keeps open.

Overall risk with reasoning formulation, not a pasted tier

Do: document the level under your rubric plus rationale: state vs baseline, dynamic and historical factors, accessible protective factors, foreseeable changes.
Pitfall: the screener category pasted in as the overall level, with no reasoning.

Actions completed not recommended

Do: safety plan, means-safety counseling (category level), monitoring, consultation outcome, confirmed handoff, proportionate disposition.
Pitfall: reflex dispositions; no authority makes admission or one-to-one automatic, and 1 to 2% of those screened need acute care.

Follow-up and reassessment owner, date, triggers

Do: name who owns the next contact, when re-screening is due per written policy, and the immediate-reassessment triggers.
Pitfall: invented universal intervals; "every encounter" and "annual" are program rules, not instrument rules.

Before the note is signed

- [ ] Version named with timeframe and mode
- [ ] Branches completed; limits recorded
- [ ] Result recorded at category level, under named policy
- [ ] Positive screen assessed same visit, documented
- [ ] Overall level carries its clinical reasoning
- [ ] Actions completed and disposition justified
- [ ] Follow-up owner, date, and triggers written

Drafting with AI

Give it category-level facts only: version, highest ideation category, behavior category, recency, protocol result, and the actions taken.

> *"Draft C-SSRS documentation: Screener Recent positive today, active ideation without intent, no behavior category, assessed same visit, continuing outpatient with safety plan updated."*

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

Categories	4 to 10 chart lines	1 to 3 minutes	Free healthcare use
not a summed score	plus the triggered assessment	screener completion	licensed for clinical trials

C-SSRS Documentation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Practice/unit: | Patient (initials): | Date and time:

Version: Screener Recent / Lifetime-Recent / Since Last Contact: | Administered by (role): | Mode:

Result (category level only)

Highest ideation category · behavior category or none identified · recency · branches completed · positive or negative under named local protocol

If positive: same-visit assessment reference

Evidence-based assessment completed and documented: ideation, plan, intent, behavior, risk factors, protective factors, collateral · where it lives in the record

Overall risk and rationale (clinician formulation)

Level under your rubric · state vs baseline · dynamic and historical factors · protective factors and current accessibility · foreseeable changes

Actions completed

Safety plan updated · means-safety counseling (category level) · monitoring status · consultation and outcome · confirmed handoff · disposition and why proportionate

Follow-up and reassessment

Next contact owner and date · re-screen due per written policy · immediate triggers: status change, new ideation, new behavior, care transition

Declined or incomplete screening

Version offered · refusal or inability and stated reason · alternative sources used · limitations · assessment and safety actions taken anyway · never charted as negative

Clinician (name and credentials): | Signature: | Date: