Suicide Risk Assessment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A suicide risk assessment records how a clinician evaluated suicide risk: the direct inquiry, weighing of current factors, a formulation with reasoning, and the actions taken. No statute prescribes the layout; the standard it is held to is a reasonable, documented process whose formulation supports the disposition.

Reason for assessment & context what prompted it
Do: record the trigger (screen result, disclosure, intake, transition) plus precipitants, symptom course, substance use, and scores.
Pitfall: a positive screen with no documented follow-up is the most indefensible gap a chart can carry.

Suicide inquiry asked directly, shown fully
Do: document ideation (frequency, duration, recency), plan, intent, and behavior history: attempts, preparatory acts, self-harm.
Pitfall: "denies SI" standing alone. Record what was asked and endorsed, not only the denial.

Access to means a conversation, not a checkbox
Do: ask about firearms by name plus anything this client's situation makes relevant; record the restriction steps agreed.
Pitfall: recording the conclusion ("no access") with no conversation shown, or stopping at firearms.

Risk & protective factors this client, today
Do: separate acute from chronic risk factors, and make protective factors specific and current.
Pitfall: protective factors copied forward unchanged; reviewers read that as boilerplate, and boilerplate cuts both ways.

Instruments & scores structure, not substitute
Do: record any screener or scale used (C-SSRS, PHQ-9, ASQ) with result and date.
Pitfall: treating the score as the assessment; no instrument replaces the formulation or supports a disposition by itself.

Risk formulation the load-bearing paragraph
Do: characterize acute and chronic risk and give the rationale connecting the findings to it.
Pitfall: a level with no reasoning, or prediction language. The standard is a reasonable documented process, never an accurate prediction.

Interventions done, dated, with consent
Do: record the safety plan as completed, means-safety steps, supports involved with consent, treatment changes, crisis resources given.
Pitfall: a "no-suicide contract" as the intervention; it has no protective evidence and reads poorly in review.

Disposition, follow-up & reassessment risk tracked forward
Do: record the level of care with its reasoning, a dated next contact, escalation instructions, consultation, and when risk is reassessed.
Pitfall: "will monitor" with no date and no reassessment plan; risk assessed once and dropped reads as abandoned.

Before you sign

- [ ] Inquiry shows endorsed and denied, with recency
- [ ] Means conversation recorded, steps agreed
- [ ] Formulation states level and rationale
- [ ] Disposition follows from the formulation
- [ ] Interventions completed, consent noted
- [ ] Next contact dated, escalation instructions given
- [ ] Reassessment plan recorded
- [ ] Signed with credentials, dated promptly

Drafting with AI

Capture 30 seconds of bullets after the session: trigger, what the client endorsed and denied, means conversation, factors, your formulation and level, interventions, disposition, next contact.

"Draft a suicide risk assessment note from these bullets for an outpatient therapy client with new passive ideation, no plan or intent: …"

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

200–800 words	10–25 min by hand	Intake · new ideation · post-crisis	Care team · auditors · legal
typical length	clinical team estimate	when completed	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/suicide-risk-assessment

Suicide Risk Assessment Template

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

Client (initials): Date: Setting: ☐ office ☐ telehealth ☐ inpatient/ED ☐ other

Triggered by: ☐ intake ☐ screening result ☐ disclosure ☐ post-crisis ☐ transition in care

Context & precipitants

Symptom course, current stressors, substance use; instruments & scores with dates (C-SSRS, PHQ-9, ASQ)

Suicide inquiry

Ideation: frequency, duration, recency · plan · intent · behavior history: attempts, preparatory acts, self-harm

Access to means

Asked directly, firearms by name; restriction steps agreed and recorded

Risk factors

Acute / chronic

Protective factors

Specific to this client, today

Risk formulation

Acute and chronic risk characterized, with the rationale connecting findings to the disposition

Interventions

Safety plan completed · means-safety steps · supports involved with consent · treatment changes · crisis resources given

Disposition & follow-up

Level of care with reasoning · dated next contact · escalation instructions given

Consultation & reassessment plan

Who was consulted and when · when risk will be reassessed

Clinician signature / credentials: Date signed: