CAMS SUICIDE STATUS FORM–4 (SSF-4) OUTCOME/DISPOSITION FINAL SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain:**	**1**	**2**	**3**	**4**	**5**	**:High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress:**	**1**	**2**	**3**	**4**	**5**	**:High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation:**	**1**	**2**	**3**	**4**	**5**	**:High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness:**	**1**	**2**	**3**	**4**	**5**	**:High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate:**	**1**	**2**	**3**	**4**	**5**	**:High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will *not* kill self)**	**1**	**2**	**3**	**4**	**5**	**:Extremely high risk (will kill self)**

In the past week:

Suicidal Thoughts/Feelings Y N Managed Thoughts/Feelings Y N n/a Suicidal Behavior Y N

Where there any aspects of your treatment that were particularly helpful to you? If so, please describe:

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (*Clinician*):

Third consecutive session of resolved suicidality: Yes No (If no, continue CAMS tracking)

**Resolution of suicidality, if for third consecutive week: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

Continuing outpatient psychotherapy

Inpatient hospitalization

Mutual termination

Patient chooses to discontinue treatment (unilaterally)

Referral to: _____

Other. Describe: _____

Next Appointment Scheduled (if applicable):

_____ _____

Patient Signature Date Clinican Signature Date