

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

Rate and fill out each item according to how you feel right now.
Rank Then rank in order of importance 1 to 5 (1=most important to 5=least important).

CAMS Suicide Status Form (SSF-5) First Session

Section B (Clinician):

Y N Suicide ideation Describe: _____

○ Frequency _____ per day _____ per week _____ per month
 ○ Duration _____ seconds _____ minutes _____ hours

Y N Suicide plan When: _____

Where: _____

How: _____ Access to means Y N

How: _____ Access to means Y N

Y N Suicide preparation Describe: _____

Y N Suicide rehearsal Describe: _____

Y N History of suicidal behaviors

- Single attempt Describe: _____
- Multiple attempts Describe: _____

Y N Impulsivity Describe: _____

Y N Substance abuse Describe: _____

Y N Significant loss Describe: _____

Y N Relationship problems Describe: _____

Y N Burden to others Describe: _____

Y N Health/pain problems Describe: _____

Y N Sleep problems Describe: _____

Y N Legal/financial issues Describe: _____

Y N Shame Describe: _____

Section C (Clinician):

CAMS TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	<i>Self-Harm Potential</i>	<i>Safety and Stability</i>	<i>CAMS Stabilization</i> <i>Plan Completed</i> ☐	
2				
3				

YES ____ NO ____ Patient understands and concurs with treatment plan?

YES ____ NO ____ Patient at imminent danger of suicide (hospitalization indicated)?

Patient Signature

Date

Clinician Signature

Date

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____
2. _____
3. _____

Things I can do to cope differently when I am in a suicide crisis:

1. _____
2. _____
3. _____
4. _____
5. _____

6. **Life or death emergency contact number:** _____

People I can call for help or to decrease my isolation:

1. _____
2. _____
3. _____

Attending treatment as scheduled:

Potential Barrier:

Solutions I will try:

1. _____
2. _____

Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____
ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____
THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: _____
ABSTRACTION: WNL NOTABLY CONCRETE
OTHER: _____
SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____
MEMORY: GROSSLY INTACT
OTHER: _____
REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

CLINICAL JUDGEMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check and explain):

☐ None Explanation: _____
☐ Mild
☐ Moderate _____
☐ Serious _____
☐ Extreme _____

CASE NOTES:

Next Appointment Scheduled: _____ Treatment Modality: _____

Clinician Signature

Date

Supervisor Signature (if indicated)

Date