

# Hospital Data Abstraction Form

OMB No. XXXX-XXXX

Expiration Date: Month Year

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is XXXX-XXXX. Public reporting burden for this collection of information is estimated to average 2 minutes per client per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 2-1057, Rockville, Maryland, 20857.

1. Patient ID:

2. Date of ED Admission:

3. Gender:

4. Age:

5. Ethnicity:

6. Diagnosis Code(s) (ICD-9 or ICD-10): \_\_\_\_\_

7. Prior Suicide Attempt(s)? ☐ Yes ☐ No

7a. If yes, how many? \_\_\_\_\_

8. Discharged to:

☐ Intensive Care

☐ Medical or Surgical Ward

☐ Inpatient Psychiatric Ward

☐ Outpatient Psychiatric/MH/BH Treatment

☐ Community

☐ Other (please specify): \_\_\_\_\_

9. Prior ED admissions for suicide-related behavior ? ☐ Yes ☐ No

9a. If yes, how many? \_\_\_\_\_

9b. For all suicide-related ED admissions within one year prior to the index admission, please provide:

Date of Admission:

Diagnosis Code:

Discharge Status:

i.

ii.

iii.

10. Subsequent ED admissions for suicide-related behavior? ☐ Yes ☐ No

10a. If yes, how many? \_\_\_\_\_

**10b.** For all suicide-related ED admissions within one year following the index admission, please provide:

Date of Admission:

Diagnosis Code:

Discharge Status:

i.

ii.

iii.

11. Patient accepted referral to crisis center for follow-up?      ☐ Yes    ☐ No    ☐ N/A