OMB No. 0930-0286
Expiration Date: XXXXX

Early Identification, Referral, Follow up, and Treatment Form – Individual (EIRFT-I)

Directions: The following information should be completed by a professional for youth—ages 10–24—who are identified as at risk by a trained gatekeeper or screening tool as part of your GLS program. This form should be completed for every new identification of suicide risk that is made by a trained gatekeeper or screening tool, as a result of GLS activities. As you complete the form, please note that all entries and descriptions of other should not use acronyms or any local terms; please be sure that you only select other when none of the available response options apply and that your descriptions of other be sufficient for someone who is not familiar with your program or community to interpret

Section 1: Demographics

1. **Participant ID (*Assigned by site)***	
2. **Age (*in years)***	
3**. Gender**	o Male o Female o Transgender (Female to Male) o Transgender (Male to Female) o Gender non-conforming o Information missing/refused o Other, please specify
4. **Sexual Orientation**	o Straight or Heterosexual o Homosexual (Gay Or Lesbian) o Bisexual o Queer o Pansexual o Questioning o Asexual o Information Missing o Other, Please Specify
5. **Race/Ethnicity** *Select all that apply*	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino

	☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other, please specify: ☐ Information Missing
6. **Please select the primary reason this youth is in your continuity of care and follow up process?**	o Identified via a GLS funded screening or by a trained gatekeeper *[Continue to Section 2]* o Discharged from an emergency department for suicidal ideation or after a suicide attempt *[Go to Section 3]* o Discharged from an inpatient psychiatric unit for suicidal ideation or after a suicide attempt *[Go to Section 4]*

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Section 2: Identification Information

7**. Date of identification**	MM/DD/YYYY
8. **Did this identification occur virtually or in person?**	o Virtual o In person
9. **ZIP code where the youth was identified**	
10. **How was this youth identified as being at risk?**	o Gatekeeper o Screening o Other, please specify
11. **Where was the youth first identified?** *location/setting of first identification*	
o School or School Based Health Center o Social Service Agency (child welfare, supportive housing) o Juvenile Justice Agency (pre-trial services, mental health court) o Law Enforcement Agency (police, jail or detention center) o Community based organization, recreation or after school activity (Boys & Girls club, faith-based organization, AA, job training programs) o Physical Health Agency (pediatrician, primary care, hospital)	o Mental Health Setting (private MH provider, psychiatric hospital, outpatient clinic) o Home o Emergency Response Unit or Emergency Department o College or University (campus health center, classroom) o Digital or social media (Snapchat, TikTok, Instagram, text message to a friend) o Don't Know o Other: Please specify
12. **Was this a tribal setting?**	o Yes o No
13. **Who first identified the youth as being at risk for suicide?** *Who first noticed that the youth was in need of assessment, or who conducted the screening that identified the youth?*	
o School-based mental health service provider (including college or university providers) school counselor, social worker, guidance counselor, nurse)	o Child welfare or social service staff o Probation officer or other juvenile justice staff o Pediatrician or primary care provider

o Family member/foster family member/caregiver o Mental health service provider except school-based providers (clinician, private counselor) o Teacher or other non-mental health school staff (including college or university staff) (principal, sports coach, resident staff) o Community based organization, recreation, religious or after school program staff	o Emergency Responder or other emergency room staff o Police officer, security guard, or other law enforcement staff o Peer o Self (the youth themselves) o Don't Know o Other: Please specify
14. **Was this individual trained as a gatekeeper**	o Yes o No [*Go to 15*] o Don't know [*Go to 15*]
a. **Please select the type of training the gatekeeper received.** *Select all that apply*	
☐ American Indian Life Skills Development ☐ Applied Suicide Prevention Intervention Skills Training (ASIST) ☐ Assessing and Managing Suicide Risk (AMSR) ☐ Campus Connect Suicide Prevention Training for Gatekeepers ☐ Connect Suicide Postvention Training ☐ Counseling on Access to Lethal Means (CALM) ☐ Kognito At-Risk ☐ Lifelines	☐ QPR (Question, Persuade, Refer) ☐ Recognizing and Responding to Suicide Risk (RRSR) ☐ Response (A Comprehensive High School-based Suicide Awareness Program) ☐ SafeTALK ☐ Signs of Suicide (SOS) ☐ Sources of Strength ☐ Yellow Ribbon ☐ Youth Depression Suicide: Let's Talk ☐ Locally Developed, please specify: ☐ Other, please specify: ☐ Don't Know
15. **Please enter the approximate month and year the gatekeeper was most recently trained.** *If the gatekeeper received more than one training, please indicate the date of their most recent training.*	MM/YYYY
16. **At the time of identification, was the youth screened for suicide risk (was a screening tool administered to determine whether the youth is at risk for suicide)?**	o Yes *[Continue to 16a]* o No *[Skip to 17]* o Don't know *[Skip to 17]*
a. **What screening tool was used?** *Select all that apply.*	
o Patient Health Questionnaire (PHQ-9) o Columbia Suicide Severity Rating Scale (CSSR-S) o Behavioral Health Screen (BHS) o Ask Suicide Screening Questions (asQ) o Beck Depression Inventory (BDI) o Suicide Behaviors Questionnaire (SBQ-R)	o Screening Tool in Signs of Suicide (SOS) o SAFE-T o Patient Safety Screener (PSS-3) o Locally developed screening tool o Other, please specify:

17. **What the youth determined to be in need of a referral?**		o Yes [Continue to Section 5] o No *[Complete 17 a and then end form]*
	a. **Please indicate why the youth was determined not to be in need of a referral.**	

Section 3: Emergency Department Services

[This section if you selected, "Discharged from an emergency department after a suicide attempt" for question 7.

18. **What was the date of Emergency Department admission?**		o MM/DD/YYYY
19. **What was the date of Emergency Department discharge?**		o MM/DD/YYYY
20. **While in the emergency department what services did the youth receive?** *Select all that apply*		☐ Mental health assessment ☐ Substance use assessment ☐ Mental health Counseling ☐ Substance abuse counseling ☐ Medication ☐ Tribal or cultural services ☐ Don't Know ☐ Other, please specify
21. **While in the emergency department, did the youth receive any of the following services?** *Select all that apply*		☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment
22. **Prior to the visit to the Emergency Department, was this youth receiving MH services?**		o Yes *[Continue to 22a]* o No *[Skip to question 23]* o Don't know *[Skip to question 23]*
	a. **What MH services was the youth receiving prior to the visit to the ED?**	
	☐ Mental health assessment ☐ Substance use assessment ☐ Mental health counseling ☐ Substance abuse counseling ☐ Inpatient or residential psychological services	☐ Medication ☐ Tribal or cultural services ☐ Case Management ☐ Stabilization ☐ Don't Know ☐ Other, please specify
23. **Did the youth receive any of the following services prior to the visit to the Emergency Department?**		☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment
CONTINUE TO SECTION 5		

Section 4: Inpatient Psychiatric Unit Services

[This section if you selected, "Discharged from an Inpatient Psychiatric Unit after a suicide attempt" for question 7.

24. **What was the date of Inpatient Psychiatric**	o MM/DD/YYYY

Unit admission?	
25. **What was the date of Inpatient Psychiatric Unit discharge?**	o MM/DD/YYYY
26. **While in the Inpatient Psychiatric Unit what services did the youth receive?** *Select all that apply*	☐ Mental health assessment ☐ Substance use assessment ☐ Mental health counseling ☐ Substance abuse counseling ☐ Medication ☐ Tribal or cultural services ☐ Don't Know ☐ Other, please specify
27. **While in the Inpatient Psychiatric Unit, did the youth receive any of the following services?** *Select all that apply*	☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment
28. **Prior to the stay in the Inpatient Psychiatric Unit, due to suicidal ideation or an attempt, was this youth receiving MH services?**	o Yes *[Continue to 28a]* o No *[Skip to Section XX]* o Don't know *[Skip to Section XX]*

	a. **What MH services was the youth receiving prior to the stay in the Inpatient Psychiatric Unit?**	
	☐ Mental health assessment ☐ Substance use assessment ☐ Mental health counseling ☐ Substance abuse counseling ☐ Medication	☐ Tribal or cultural services ☐ Case management ☐ Stabilization ☐ Don't Know ☐ Other, please specify
29. **Did the youth receive any of the following services prior to the stay in the Inpatient Psychiatric Unit?**		☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment
CONTINUE TO SECTION 5		

Section 5: Referral Information

30. *[Question based on pathway]* **Upon discharge from the [inpatient psychiatric unit/Emergency Department], did the youth receive referrals for additional mental health services? Was the youth referred to mental health services and/or other supports as a result of having been identified as being at risk for suicide?**		o Yes *[inpatient/ER path continue to 31a; other continue to 31b]* o No [SKIP to 31e, then end form] o I don't know [SKIP to 31f, then end form]
	a. **How were referrals made?**	☐ Appointment(s) set up before discharge ☐ Youth/parent given referral information, but must schedule their own appointment ☐ Both ☐ Other, please specify ☐ Don't know
	b. **What was the date of referral?**	MM/DD/YYYY

	c. **To which of the following mental health services was the youth referred?** *Select all that apply*	
	☐ Public Mental Health Agency or Provider (tribal or state sponsored mental health agency) ☐ Private Mental Health Agency/Provider ☐ Psychiatric Hospital/unit ☐ Emergency department ☐ Substance abuse treatment center ☐ School counselor (K-12 or college or university staff)	☐ Mobile crisis unit ☐ School based health clinic ☐ Tribal or cultural services (traditional healing practices, talking circles, sweat lodge) ☐ Non-hospital crisis stabilization unit ☐ Youth was not referred to mental health services ☐ Don't Know ☐ Other, please specify
	d. **To which of the following other supports was the youth referred**? *Select all that apply.*	
	☐ School or academic organization (school club, academic counseling, tutoring) ☐ Family or extended family (parent, foster parent, grandparent, aunt, uncle) ☐ Community based organization, recreation religious, afterschool program (Boys & Girls club, faith-based organization, AA, job training programs) ☐ Physical health provider (pediatrician, primary care provider)	☐ Law enforcement/ Juvenile justice agency (pre-trial services, mental health court, police) ☐ Social service agency (child welfare, supportive housing) ☐ Crisis hotline (988, local crisis hotline, text msg hotline) ☐ Youth was not referred to other supports ☐ Don't Know ☐ Other, please specify
	e. **Why not?** *Select one primary reason*	
	☐ Youth was already receiving services or supports ☐ No capacity at provider agencies to receive a referral ☐ Youth or parent refused services	☐ Unable to contact youth ☐ Don't know ☐ Other, please specify
	f. **Why don't you know?** *Select one primary reason.*	
	☐ Parent permission for tracking required but not granted ☐ No tracking system in place ☐ Tracking system requires an agreement to share data, but the agreement is not in place	☐ Tracking system prohibits data sharing ☐ Parent or youth could not be contracted ☐ Don't know ☐ Other, please specify

Section 6: Follow up and Treatment Receipt

This set for questions repeats for each of the 6 months post referral/discharge

31. **In the [first/second/third/fourth/fifth/sixth] month following discharge from the [emergency department/inpatient psychiatric unit] did someone reach out to provide a supportive or caring contact**	o Yes *[Continue to 31a]* o No [Skip to question 32] o Don't know [Skip to question 32]

for the purpose of expressing care or concern for the youth?		
	a. **Please describe the caring contact(s) with this youth?**	
32. **In the [first/second/third/fourth/fifth/sixth] month following discharge from the [emergency department/inpatient psychiatric unit] did someone contact the youth for the purpose of checking in on the status of the youth, for care coordination, or to check in on service receipt?**		o Yes *[Continue to 32a]* o No [Skip to question 33] o Don't know [Skip to question 33
	a**. Please describe the follow up contact(s) with this youth?**	
33. **In the [first/second/third/fourth/fifth/sixth] month following the *[date of referral/date of discharge*], did the youth receive a mental health service(s) as a result of the mental health referral?**		o Yes *[Continue to 33a]* o No [Skip to question 33g] o Don't know [Skip to question 33h]
	a. **As a result of the referral, which of the following services did the youth receive in the [first] month since referral?** *Select all that apply.*	
	☐ Mental health assessment (assessment of psychosocial needs and conditions) ☐ Substance use assessment ☐ Mental health counseling (outpatient group or individual counseling) ☐ Substance abuse counseling (inpatient or outpatient, group or individual) ☐ Inpatient or residential psychological services ☐ Medication	☐ Tribal or cultural services ☐ Case management ☐ Stabilization ☐ Don't Know ☐ Other, please specify
	b. **As a result of the referral, did the youth receive any of the following services in the [first/second/third/fourth/fifth/sixth] month since referral?** *Select all that apply.*	☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment
	c. **Which of these services was received first after the referral?** *[FIRST TIME YES IS SELECTED CONTINUE TO 33 Complete 33 c and d]. ALL OTHER TIMES SKIP TO 33e]*	
	☐ Mental health assessment (assessment of psychosocial needs and conditions) ☐ Substance use assessment ☐ Mental health counseling (outpatient group or individual counseling) ☐ Substance abuse counseling (inpatient or outpatient, group or individual) ☐ Inpatient or residential psychological services Medication	☐ Tribal or cultural services ☐ Case management ☐ Stabilization ☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment ☐ Don't Know ☐ Other, please specify
	d. **What is the zip code for where this first service occurred?**	
	e. **Were any of these services provided via tele-health or virtual appointments?**	o Yes o No

		o Don't know
	f. **Which of the services were provided via telehealth?** [*Continue to 34]*	
☐ Mental health assessment (assessment of psychosocial needs and conditions) ☐ Substance use assessment ☐ Mental health counseling (outpatient group or individual counseling) ☐ Substance abuse counseling (inpatient or outpatient, group or individual) ☐ Inpatient or residential psychological services Medication		☐ Tribal or cultural services ☐ Case management ☐ Stabilization ☐ Means restriction counseling ☐ Safety planning ☐ Suicide risk assessment ☐ Don't Know Other, please specify
	g. **Why not?** *Select one primary reason* [*then 32]*	
	o Made an appointment for youth, but youth did not attend o Youth was waitlisted o Parent or youth refused service for non-financial reasons o Youth did not have insurance or could not afford services	o Youth did not have transportation to the appointment o Appointment made, but in the future o Don't Know o Other, please specify:
	h. **Why don't you know?** *Select one primary reason* [*then 34]*	
	o Parent permission for tracking required but not granted o No tracking system in place o Tracking system requires an agreement to share data but the data agreement is not in place	o Tracking system prohibits data sharing o Parent or youth could not be contacted (parent or youth moved) o Don't Know o Other, please specify:
34. **Did the youth receive any services beyond those to which they were referred?** (this may include services *in addition* to those to which they were initially referred or services they had already started prior to identification and referral)		o Yes *[Continue to 34a]* o No [SKIP to 35] o Don't know [SKIP to 35]
	a. **What additional services were received?** *Select all that apply*	
	☐ Mental health assessment (assessment of psychosocial needs and conditions) ☐ Substance use assessment ☐ Mental health Counseling (outpatient group or individual counseling) ☐ Substance abuse counseling (inpatient or outpatient, group or individual) ☐ Inpatient or residential psychological services ☐ Medication	☐ Tribal or cultural services ☐ Case management ☐ Stabilization ☐ Don't Know ☐ Other, please specify
	b. **Did the youth also receive any of these services?**	o Means restriction counseling o Safety planning o Suicide risk assessment
35. **Was it determined that they youth needed**		o Yes *[Continue to 35a]*

	additional referrals?	o No [*END MONTHLY REPORT*] o Don't know [*END MONTHLY REPORT*]
	a. What additional referrals did the youth receive during [MONTH]? *Select all that apply*	
	☐ Public Mental Health Agency or Provider (tribal or state sponsored mental health agency) ☐ Private Mental Health Agency or Provider ☐ Psychiatric Hospital/ Unit ☐ Emergency department ☐ Substance abuse treatment center ☐ School counselor (K-12 or college or university staff) ☐ Mobile crisis unit	☐ School Based Health Clinic ☐ Tribal or cultural services (traditional healing practices, talking circles, sweat lodge) ☐ Youth was not referred to mental health services ☐ Non-hospital Crisis stabilization unit ☐ Don't Know ☐ Other, please specify