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TRAINING: The SSF should only be used by persons who have been properly trained. You may obtain training through CAMS-care.

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 ◯ Suicidal Behavior Y ◯ N ◯

Where there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

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

From David Jobes, *Managing Suicidal Risk: A Collaborative Approach, Second Edition* © 2016 by The Guilford Press. www.guilford.com.