

**Informed Consent – CAMS**

As per my treatment plan developed in collaboration with my therapist, I understand that we will be working together using the CAMS model to address my therapeutic needs with a focus on my suicidal feelings and behavior. If, through the course of treatment, we determine that I will need additional treatment beyond the scope of services Purdue CAPS can offer, or beyond the session limits of CAPS, I understand that my therapist will assist me in finding other, more appropriate treatment options in the community.

\_\_\_\_\_  
*Client's signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*PUID*

**This page intentionally left blank**

## INTAKE CAMS SUICIDE STATUS FORM-4 (SSF-4) INITIAL SESSION

Client: \_\_\_\_\_ Clinician: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

### Section A (Client):

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

_____	1) RATE PSYCHOLOGICAL PAIN ( <i>hurt, anguish, or misery in your mind, <u>not</u> stress, <u>not</u> physical pain</i> ):	Low pain: 1 2 3 4 5 :High pain	
	What I find most painful is: _____		
_____	2) RATE STRESS ( <i>your general feeling of being pressured or overwhelmed</i> ):	Low stress: 1 2 3 4 5 :High stress	
	What I find most stressful is: _____		
_____	3) RATE AGITATION ( <i>emotional urgency; feeling that you need to take action; <u>not</u> irritation; <u>not</u> annoyance</i> ):	Low agitation: 1 2 3 4 5 :High agitation	
	I most need to take action when: _____		
_____	4) RATE HOPELESSNESS ( <i>your expectation that things will not get better no matter what you do</i> ):	Low hopelessness: 1 2 3 4 5 :High hopelessness	
	I am most hopeless about: _____		
_____	5) RATE SELF-HATE ( <i>your general feeling of disliking yourself; having no self-esteem; having no self-respect</i> ):	Low self-hate: 1 2 3 4 5 :High self-hate	
	What I hate most about myself is: _____		
N/A	6) RATE OVERALL RISK OF SUICIDE:	Extremely low risk: 1 2 3 4 5 :Extremely high risk (will not kill self) (will kill self)	

- 1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely  
 2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much  
 I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: \_\_\_\_\_

**This page intentionally left blank**

**Section B (Clinician):**

Y    N    Suicidal Ideation    Describe: \_\_\_\_\_

• Frequency \_\_\_\_\_ per day    \_\_\_\_\_ per week    \_\_\_\_\_ per month

• Duration \_\_\_\_\_ seconds    \_\_\_\_\_ minutes    \_\_\_\_\_ hours

Y    N    Suicide Plan(s)

When: \_\_\_\_\_

Where: \_\_\_\_\_

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):**

**TREATMENT PLAN**

Client Status:

Discontinued treatment  Hospitalization  Referred/Other:

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

YES \_\_\_ NO \_\_\_ Client understands and concurs with treatment plan?

YES \_\_\_ NO \_\_\_ Client at imminent danger of suicide (hospitalization indicated)?

I understand that I am taking with me information that is part of my confidential clinical record and am responsible for how this information is shared once it is in my possession. My therapist has reviewed with me, the risks associated with having confidential information in my possession.

---

*Client Signature*                      *Date*    *PUID*

Client offered copy of this form and declined

Client was provided with a copy of this form

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

**This page intentionally left blank**



**CAMS STABILIZATION PLAN**

- Stabilization Plan from previous appointment reviewed with client
- Client reported that previous Stabilization Plan remains effective and useful; no updates made.

Ways to reduce access to lethal means:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

- 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. \_\_\_\_\_

If the suicidal thoughts continue and become specific, and I find myself preparing to harm myself:

1. I will call CAPS, (765) 494-6995 and speak with my therapist, the therapist on duty, or the after-hours clinician.

2. I will go to the emergency room at:

St. Elizabeth East (765) 502-4400  
1701 S. Creasy Ln.  
Lafayette, IN

IU Health Arnett Hospital  
5165 McCarty Ln.  
Lafayette, IN  
(765) 448-8000

Sycamore Springs (765) 743-4400  
833 Park East Blvd.  
Lafayette, IN

3. Call 911

4. I will call CAPS as soon as possible to inform my therapist about my situation.

\_\_\_\_\_  
Client Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
PUID

