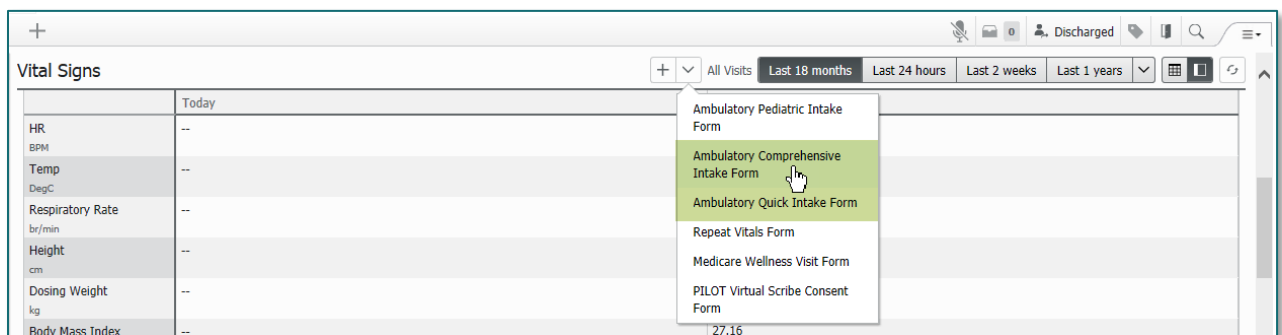


Screening for depression is documented in the ambulatory setting using the applicable Intake form. Screening results appear in the Scales and Assessments component, where the provider may access the Columbia Suicide Risk Severity Rating Scale (CSSRS) screening form for completion. The workflow is detailed below.

## Depression Screening at Intake

Depression screening is performed and documented by the clinical staff member responsible for the patient intake. Each intake form has the applicable screening tool(s) embedded for this purpose. For the purposes of this flyer, the PHQ 2 and PHQ 9 scales will be demonstrated.

**STEP 1:** Select the Intake Form from the Vital Signs component documentation dropdown menu.



**STEP 2:** During the course of the intake, complete the Depression Screening Tool documentation.

- The Patient Health Questionnaire requires that all questions in PHQ 2 be asked first.
- The Initial Depression Screening Score will display. If the score is 2-6, continue to the questions in PHQ 9.
- Be sure to use the scrollbar to answer every question.
- Click the **green** checkmark to sign the PowerForm.



Ambulatory Comprehensive Intake Form - EDUCATION, MABLINCRNI

\*Performed on: 10/12/2021 1353 EDT

ID Risk Screen  
Summary  
Allergies  
Medication List  
Nursing HPI  
Advance Directive  
CPC- Health Status Evaluations  
Depression Screening Tool Ate PHQ  
Procedure History  
Social History  
Alcohol Screening  
Social Determinants of Health  
Family History  
OB/GYN History  
Psychosocial  
Religious/Spiritual/Cultural  
STADI Fall Risk (Pt age 65 or older)  
Hearing, Vision and Cognitive Screening  
ROS  
CSSRS Screen  
IADL  
Education Needs  
Med Management Documentation  
Oswestry Disability Index

**Patient Health Questionnaire - PHQ 2**

Depression Screening Refused  
 Yes  
 No

Depression Screening Last Reviewed

How often have you been bothered by the below symptoms over the last two weeks?

Feeling Down, Depressed, Hopeless  
 Not at all  
 Several days  
 More than half the days  
 Nearly every day

Little Interest, Pleasure in Activities  
 Not at all  
 Several days  
 More than half the days  
 Nearly every day

Initial Depression Screening Score

The questions above are the first step of the PHQ. For a score of 2-6, complete the remaining questions. A score less than 2 is negative and no additional evaluation is needed at this time.

**Patient Health Questionnaire - PHQ 9**

Instructions: Over the last two weeks, how often have you been bothered by the following problems?  
 Choose the answer that best describes how often you were bothered by the following problems?

Trouble Falling or Staying Asleep  
 Not at all  
 Several days  
 More than half the days  
 Nearly every day

Poor Appetite or Overeating  
 Not at all  
 Several days  
 More than half the days  
 Nearly every day

## CSSRS Screening

Results from the depression screening display in the **Scales and Assessments** component. The component is viewed to clinical personnel and providers. If indicated, a CSSRS screening should be performed. (Please refer to organizational and regulatory requirements, as well as professional standards for guidance.) For this example, the **CSSRS Screening Form** is used.

Scales and Assessments		+ ▾	All Visits	Last 1 years	Last 2 years	Last 5 years	↻
	OCT 12, 2021 13:53						
Depression Screen Seve...	20-27 Positive; Severe						
Initial Depression Scree...	5						
Thoughts Better Off De...	More than half the days						
Total Depression Scree...	21						

**STEP 1:** Select the **CSSRS Screening Form** from the **Scales and Assessments** component documentation drop-down menu.

The screenshot shows the 'Scales and Assessments' component in an EHR system. A dropdown menu is open, listing various assessment forms. The 'C-SSRS Screening Form' is highlighted in green. Below the dropdown, the 'Scales and Assessments' table is visible, showing a table with columns for 'Today' and 'Previous' for various vital signs. The table data is as follows:

	Today	Previous
HR BPM	--	150 MAY 06, 2020 11:29
Temp DegC	--	39 MAY 06, 2020 11:21
Respiratory Rate br/min	--	40 MAY 06, 2020 11:21
Height cm	--	180 MAY 06, 2020 13:54
Dosing Weight kg	--	88 MAY 06, 2020 13:54
Body Mass Index kg/m2	--	27.16 MAY 06, 2020 13:54

- STEP 2:** Complete the **CSSRS Screening Tool** documentation. (See next page for screenshot of form.)
- The questions on this form should be asked in the order presented.
  - The patient questions are in **bold, underlined font**.
  - Be sure to use the scrollbar to answer every question and to find the **Response Protocol**.
  - The **Response Protocol** is located in **blue font** at the bottom of the form, beneath the ED Only questions.
  - Responses are linked to the **last question with a "Yes" answer** from the patient.
  - Click the **green** checkmark to sign the PowerForm.

## CSSRS Screening Form

C-SSRS Screening Form

Performed on: 10/13/2021 1648 EDT

CSSRS Screen

Ask questions that are **BOLD and Underlined**

Ask questions 1 and 2

**1. In the past month, have you wished you were dead or wished you could go to sleep and not wake up? (Ref)**  Yes  No

(Right click for reference text.)

**2. In the past month, have you actually had any thoughts of killing yourself? (Ref)**  Yes  No

If Yes to 2, ask questions 3, 4, 5, and 6. If NO, go directly to question 6a

**3. In the past month, have you been thinking about how you might kill yourself? (Ref)**  Yes  No

*E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it.... and I would never go through with it."*

**4. In the past month, have you had these thoughts and had some intention of acting on them? (Ref)**  Yes  No

*As opposed to "I have the thoughts, but I definitely will not do anything about them."*

**5. In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? (Ref)**  Yes  No

*Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump.  
Or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.*

**6a. In the past month, have you done anything, started to do anything, or prepared to do anything to end your life? (Ref)**  Yes  No

If Yes to 6a, please answer the last question

**6b. Was this in the past month, between 1 and 12 months ago, or over a year ago?**  Within the last month  Between one and twelve months ago  Over a year ago

\*\*\*\*\* ED Only \*\*\*\*\*

**6. In your lifetime, have you done anything, started to do anything, or prepared to do anything to end your life? (Ref)**

**7. If Yes, was this in the last 3 months?**

Response Protocol to C-SSRS Screening (Linked to last item marked "Yes")

- Item 1 Behavioral Health Referral at Discharge
- Item 2 Behavioral Health Referral at Discharge
- Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 4 Immediate Notification of Physician and/or Behavioral Health and Safety Precautions
- Item 5 Immediate Notification of Physician and/or Behavioral Health and Safety Precautions
- Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
- Item 7 Immediate Notification of Physician and/or Behavioral Health and Safety Precautions

In Progress

For questions regarding process and/or policies, please contact your unit's Clinical Educator or Clinical Informaticist. For any other questions please contact the Customer Support Center at: 207-973-7728 or 1-888-827-7728.