

SUICIDE DEATH INVESTIGATION FORM

This Suicide Death Investigation Form was originally developed by the state of Colorado but has been adapted for the purposes of this toolkit. The purpose of the form is to capture risk factor and circumstance data in suspected or known cases of suicide, as well as general mortality information to be used in prevention efforts, not to determine possible negligence or accountability.

Suicide Death Investigation: Full Form

1. Administrative information:		
a. Date report completed (MM/DD/YYYY):		b. Date of incident (MM/DD/YYYY):
c. Reporting agency name:		
d. Please indicate which types of sources were available (check all that apply):		
<input type="checkbox"/> Employment/Personnel record	<input type="checkbox"/> Suicide note	
<input type="checkbox"/> Medical record	<input type="checkbox"/> Investigative report	
<input type="checkbox"/> Autopsy report	<input type="checkbox"/> Interviews	
<input type="checkbox"/> Ballistics report	<input type="checkbox"/> School records	
<input type="checkbox"/> Financial (debt) report	<input type="checkbox"/> Other, specify:	
2. Decedent information:		
a. Decedent name:	b. Date of birth (MM/DD/YYYY):	c. Date of death (MM/DD/YYYY):
First: _____	_____	_____
Middle: _____	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
Last: _____		
3. Education:		
Highest education level completed:		
<input type="checkbox"/> High school	<input type="checkbox"/> Associate degree	<input type="checkbox"/> Doctorate-level degree
<input type="checkbox"/> GED	<input type="checkbox"/> Bachelor-level degree	<input type="checkbox"/> Unknown
<input type="checkbox"/> Some college	<input type="checkbox"/> Masters-level degree	<input type="checkbox"/> Less than high school, specify highest grade completed:
4. Race (check all that apply):		5. Hispanic origin:
<input type="checkbox"/> White	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Hispanic
<input type="checkbox"/> African-American	<input type="checkbox"/> Unknown	<input type="checkbox"/> Non-Hispanic
<input type="checkbox"/> American-Indian/Alaska Native	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Unknown
6. Relationship and family status:		
a. Current relationship status:	b. Marital status	
<input type="checkbox"/> In a relationship	<input type="checkbox"/> Never married	<input type="checkbox"/> Remarried
<input type="checkbox"/> Not in a relationship	<input type="checkbox"/> Married	<input type="checkbox"/> Separated
<input type="checkbox"/> Unknown	<input type="checkbox"/> Divorced/Legally separated	<input type="checkbox"/> Living together
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Unknown
c. If separated/divorced/widowed, date (MM/DD/YYYY):		
7. Residence information:		
a. Type of residence:	b. Residing with (check all that apply):	c. Recent residence problems?
<input type="checkbox"/> House/Townhome	<input type="checkbox"/> Spouse/Significant other	<input type="checkbox"/> Recent eviction/threat of eviction
<input type="checkbox"/> Apartment	<input type="checkbox"/> Roommate(s)	<input type="checkbox"/> Recent foreclosure/threat of foreclosure
<input type="checkbox"/> Homeless	<input type="checkbox"/> Parent(s)	
<input type="checkbox"/> Treatment facility	<input type="checkbox"/> Child(ren)	
<input type="checkbox"/> Correctional facility	<input type="checkbox"/> No one, resided alone	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Other, specify:	

8. Armed services history:	
a. Military service: <input type="checkbox"/> Yes, specify years of service: <input type="checkbox"/> No military service <input type="checkbox"/> Unknown	b. Eligible for services from the VA? <input type="checkbox"/> Yes, and receiving services <input type="checkbox"/> Yes, but not receiving services <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify:
9. Employment information:	
Industry and Occupation are terms used by National Institute for Occupational Safety and Health and represent the usual or lifetime career of an individual. The occupation is the actual job or position of the individual. For more information visit: https://www.cdc.gov/niosh/docs/2012-149/pdfs/2012-149.pdf	
a. Decedent's employment status prior to death: <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unknown <input type="checkbox"/> On disability <input type="checkbox"/> Other, specify:	b. If decedent was employed, specify the occupation:
10. Incident information:	
a. By whom was the body first encountered/discovered? <input type="checkbox"/> Family member, specify relationship to decedent: <input type="checkbox"/> Coworker <input type="checkbox"/> Friend <input type="checkbox"/> Emergency responder <input type="checkbox"/> Police Officer <input type="checkbox"/> Firefighter <input type="checkbox"/> Stranger <input type="checkbox"/> Other, specify:	b. Were grief/survivor resources offered to the person(s) in range to intervene or to those who found the body? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown c. Injury location: <input type="checkbox"/> Own residence <input type="checkbox"/> Hospital/Medical facility <input type="checkbox"/> Natural area (e.g. state park) <input type="checkbox"/> Park, playground, public area <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Street/Road, sidewalk, alleyway <input type="checkbox"/> Highway/Freeway <input type="checkbox"/> School <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Industrial/Construction area <input type="checkbox"/> Parking lot/Public garage <input type="checkbox"/> Supervised residential facility <input type="checkbox"/> Other commercial establishment <input type="checkbox"/> Jail/Correctional facility <input type="checkbox"/> Other, specify:
d. Was planning or preparation involved in this death? <input type="checkbox"/> Yes (apparent ritual, preparation, etc.) <input type="checkbox"/> No (no apparent ritual, preparation, etc.) <input type="checkbox"/> Unknown	e. Any evidence the incident involved the following (check all that apply): <input type="checkbox"/> A suicide cluster (multiple suicides that fall within an accelerated time frame and within a defined geographical area) <input type="checkbox"/> Death-risk game (e.g. Russian Roulette, playing chicken, or choking game)? <input type="checkbox"/> Suicide pact with another individual?
f. Did the decedent communicate suicidal ideation or threats (e.g. days, weeks, months) prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe how was it expressed and to whom was it expressed:	g. EMS on scene: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
h. Was a suicide note found on scene? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	i. Suicide note format, if applicable: <input type="checkbox"/> Paper/physical copy <input type="checkbox"/> On cell phone <input type="checkbox"/> On personal computer <input type="checkbox"/> On social media <input type="checkbox"/> Other, specify:
j. List of prescriptions or substances found on scene:	k. Was there evidence of substance involvement? (check all that apply) <input type="checkbox"/> No <input type="checkbox"/> Alcohol <input type="checkbox"/> Stimulants <input type="checkbox"/> Depressants <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Over the counter products <input type="checkbox"/> Prescription drugs (only if prescribed to decedent) <input type="checkbox"/> Prescription drugs (not prescribed to decedent) <input type="checkbox"/> Other

11. Cause of injury leading to death:			
a. Method used to inflict fatal injury:			
<input type="checkbox"/> Firearm/Gunshot	<input type="checkbox"/> Sharp Instrument	<input type="checkbox"/> Motor vehicle collision	
<input type="checkbox"/> Jumping/fall from height	<input type="checkbox"/> Carbon monoxide/Helium/ Inhalant	<input type="checkbox"/> Other, specify:	
<input type="checkbox"/> Poisoning/overdose	<input type="checkbox"/> Hanging, strangulation, suffocation		
12. If firearm caused injury:			
a. Type of firearm used:		b. Who owned firearm?	
<input type="checkbox"/> Handgun	<input type="checkbox"/> Decedent	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Revolver	<input type="checkbox"/> Parent	<input type="checkbox"/> FirearmStolen	
<input type="checkbox"/> Shotgun	<input type="checkbox"/> Other family member	<input type="checkbox"/> Other, specify:	
<input type="checkbox"/> Rifle	<input type="checkbox"/> Friend		
<input type="checkbox"/> Other, specify:			
c. How was the firearm usually stored?		d. Firearm stored:	
<input type="checkbox"/> Locked cabinet/safe	<input type="checkbox"/> Loaded		
<input type="checkbox"/> Unlocked cabinet	<input type="checkbox"/> Unloaded		
<input type="checkbox"/> Unsecured (e.g., closet, bedside table), specify:	<input type="checkbox"/> Unloaded with ammunition		
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown		
<input type="checkbox"/> Other, specify:			
e. What were the safety features on the firearm?			
13. Life stressors:			
a. Relationship stressors (check all that apply):		b. Additional life stressors (check all that apply):	
<input type="checkbox"/> Intimate partner problem	<input type="checkbox"/> Family relationship problem	<input type="checkbox"/> Civil legal problems (e.g., divorce, bankruptcy, eviction)	<input type="checkbox"/> School problem
<input type="checkbox"/> Other relationship problem, specify:		<input type="checkbox"/> Criminal legal problems (e.g. parole, probation, arrest)	<input type="checkbox"/> Lack of housing/homelessness
		<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Suicide of friend or family member
		<input type="checkbox"/> Physical health problem	<input type="checkbox"/> Non-suicide death of friend or family member
		<input type="checkbox"/> Job problem/dissatisfaction	<input type="checkbox"/> Disaster exposure (flood, fire, etc.)
		<input type="checkbox"/> Financial problem	<input type="checkbox"/> Assault/Trauma
<input type="checkbox"/> Recent argument			
<input type="checkbox"/> Timing of argument:		Describe:	
c. Other important information:			
14. Youth suicide information (only complete for decedents under 18 at the time of death):			
a. School history (check all that apply):	b. Relationship stressors (check all that apply):	c. Family circumstances (check all that apply):	d. Type of bullying (check all that apply):
<input type="checkbox"/> School failure	<input type="checkbox"/> Argument with significant other	<input type="checkbox"/> Intact family	<input type="checkbox"/> Experienced bullying as victim
<input type="checkbox"/> Move/new school	<input type="checkbox"/> Argument with family/relatives	<input type="checkbox"/> Parents separated	<input type="checkbox"/> Participated in bullying as the perpetrator
<input type="checkbox"/> Problems with grades	<input type="checkbox"/> Breakup	<input type="checkbox"/> Parents divorced	<input type="checkbox"/> Unknown
<input type="checkbox"/> Individualized education plan	<input type="checkbox"/> Conflict with peers	<input type="checkbox"/> Ongoing custody issues	
<input type="checkbox"/> Suspension	<input type="checkbox"/> Argument with friends	<input type="checkbox"/> Single parent home	
<input type="checkbox"/> Expulsion	<input type="checkbox"/> Rumor mongering (i.e. gossip)	<input type="checkbox"/> Foster care or other out of home placement	
<input type="checkbox"/> Loss of extracurricular activities	<input type="checkbox"/> Physical abuse/assault	<input type="checkbox"/> Ongoing family discord	
Other serious school problems, specify:	<input type="checkbox"/> Rape/sexual abuse	<input type="checkbox"/> Incarcerated parent	
	<input type="checkbox"/> Online community/social media conflict	<input type="checkbox"/> Parent in the military	
	Other, specify:	Other, specify:	

15. Medical history:							
a. Did the individual have any of the following medical problems? <input type="checkbox"/> Recent life-changing diagnosis (e.g. cancer, HIV+) <input type="checkbox"/> Chronic illness/condition (e.g. back pain, migraines, diabetes) <input type="checkbox"/> Recent serious injury (i.e. car accident, fall) <input type="checkbox"/> History of brain trauma/concussion If yes, please specify and describe how recently it took place:		b. Any currently prescribed medications? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, specify the medications and who supervised the prescribed medications (e.g. psychiatrist): c. Did decedent have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
16. Substance Use Disorder history:							
a. Did the decedent have any alcohol-related problems? <input type="checkbox"/> Binge drinking <input type="checkbox"/> Alcohol use disorder or dependence <input type="checkbox"/> Driving under the influence If yes, how recent:	b. Did the decedent use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	c. Did the decedent have a history of drug overdose? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	d. Any change in alcohol or drug use behavior within 2 weeks of death? <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No change <input type="checkbox"/> Unknown				
e. Substance use disorder history (check all that apply): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> Non-prescription, illicit, or diverted substances: <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Heroin <input type="checkbox"/> Prescription opiates (not prescribed to decedent) <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Unknown Other, specify: </td> <td style="width: 50%; vertical-align: top;"> Prescription drugs: <input type="checkbox"/> Prescription opiates (only if prescribed to decedent) <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Muscle relaxants <input type="checkbox"/> Over the counter <input type="checkbox"/> Steroids <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: If yes, how recent: </td> </tr> </table>				Non-prescription, illicit, or diverted substances: <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Heroin <input type="checkbox"/> Prescription opiates (not prescribed to decedent) <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Unknown Other, specify:	Prescription drugs: <input type="checkbox"/> Prescription opiates (only if prescribed to decedent) <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Muscle relaxants <input type="checkbox"/> Over the counter <input type="checkbox"/> Steroids <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: If yes, how recent:		
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17. Mental health history:							
a. Did the decedent recently express/demonstrate any of the following? (Check all that apply): <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> A desire to die <input type="checkbox"/> Lack of interest in usual activities <input type="checkbox"/> Feelings of hopelessness/uselessness <input type="checkbox"/> Feelings of powerlessness <input type="checkbox"/> Feelings of failure </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Feelings of shame, guilt or remorse <input type="checkbox"/> Changes in eating patterns <input type="checkbox"/> Change in usual mood <input type="checkbox"/> Feeling of being a burden to others <input type="checkbox"/> Feelings of anxiety </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Running away/disappearing <input type="checkbox"/> Impulsivity <input type="checkbox"/> A desire to be free of all problems <input type="checkbox"/> Feelings of depression <input type="checkbox"/> Changes in usual sleep patterns </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Rejection by a loved one <input type="checkbox"/> Loneliness <input type="checkbox"/> Isolation <input type="checkbox"/> Self-deprecation <input type="checkbox"/> Agitation <input type="checkbox"/> Self-mutilation/cutting </td> </tr> </table>				<input type="checkbox"/> A desire to die <input type="checkbox"/> Lack of interest in usual activities <input type="checkbox"/> Feelings of hopelessness/uselessness <input type="checkbox"/> Feelings of powerlessness <input type="checkbox"/> Feelings of failure	<input type="checkbox"/> Feelings of shame, guilt or remorse <input type="checkbox"/> Changes in eating patterns <input type="checkbox"/> Change in usual mood <input type="checkbox"/> Feeling of being a burden to others <input type="checkbox"/> Feelings of anxiety	<input type="checkbox"/> Running away/disappearing <input type="checkbox"/> Impulsivity <input type="checkbox"/> A desire to be free of all problems <input type="checkbox"/> Feelings of depression <input type="checkbox"/> Changes in usual sleep patterns	<input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Rejection by a loved one <input type="checkbox"/> Loneliness <input type="checkbox"/> Isolation <input type="checkbox"/> Self-deprecation <input type="checkbox"/> Agitation <input type="checkbox"/> Self-mutilation/cutting
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b. Did decedent have a known crisis in the two weeks preceding death? <input type="checkbox"/> Yes If yes, please describe: <input type="checkbox"/> No <input type="checkbox"/> Unknown							
c. Excluding the decedent, any family history of? (Check all that apply): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Substance use disorder <input type="checkbox"/> Depression <input type="checkbox"/> Suicide gestures/attempts <input type="checkbox"/> Homicide </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Suicide <input type="checkbox"/> Child abuse/neglect <input type="checkbox"/> Domestic violence <input type="checkbox"/> Sexual assault </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Other mental health conditions, specify: </td> </tr> </table>				<input type="checkbox"/> Substance use disorder <input type="checkbox"/> Depression <input type="checkbox"/> Suicide gestures/attempts <input type="checkbox"/> Homicide	<input type="checkbox"/> Suicide <input type="checkbox"/> Child abuse/neglect <input type="checkbox"/> Domestic violence <input type="checkbox"/> Sexual assault	<input type="checkbox"/> Other mental health conditions, specify:	
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Incident/Investigation Narrative: