**Please electronically submit this form to:** **HCHHCACaseManagement@azblue.com**

**Member Name (First Last):** Click here to enter text. **DOB:** Click here to enter text.

**AHCCCS ID:** Click here to enter text. **Population:** Click here to enter text.

**BH Provider:** Click here to enter text. **Site:** Click here to enter text.

**Prescriber (BHMP):** Click here to enter text. **Phone**: Click here to enter text.

**Primary Clinician:** Click here to enter text. **Phone:** Click here to enter text.

**Suicide Attempts**

**Most Recent Suicide Attempt Date:** Click here to enter text.

**Most Recent Suicide Attempt Method:** Click here to enter text.

**If applicable,**

**Previous Attempt Date:** Click here to enter text.

**Previous Attempt Method:** Click here to enter text.

**SHOUT Eligibility Criteria (must meet at least one of the following):**

[ ] Suicide attempt via hanging, strangulation, suffocation, gassing, drowning, jumping
 from a height or use of firearm. (High Criteria) one attempt needing medical intervention.

[ ] Two or more suicide attempts, by any method, **requiring medical interventions,** within a 12-month period.

**Medical Intervention(s) Occurred: (**Medical intervention definition in SHOUT Protocol, pg 4.)

Emergency Department Admission [ ]  YES [ ]  NO

Medical Inpatient Admission [ ]  YES [ ]  NO

**Behavioral Health Intervention(s) Occurred:**

 Mobile Crisis Response [ ]  YES [ ]  NO

 Law Enforcement Involvement [ ]  YES [ ]  NO

 Psychiatric Inpatient Admission [ ]  YES [ ]  NO

 Court-Ordered Evaluation/Treatment [ ]  YES [ ]  NO

 Outpatient Treatment [ ]  YES [ ]  NO

 Completion of Crisis Prevention Plan [ ]  YES [ ]  NO

 Other: Click here to enter text.

**Follow-Up Post-Attempt:**

 Crisis Prevention Plan updated [ ]  YES [ ]  NO

 Behavioral Health Service Plan updated [ ]  YES [ ]  NO

 Outpatient BH Provider appointment date: Click here to enter a date.

 Prescriber (BHMP) appointment date: Click here to enter text.

 Prescriber (Medical) appointment date: Click here to enter a date.

**Additional Comments:**

Click here to enter text.

**Form Completed By:** Click here to enter text. **Date:** Click here to enter a date.

**Contact Phone:** Click here to enter text. **Email:** Click here to enter text.

**All information is confidential and protected by ARS §36-2401 through ARS §36-2404, ARS §36-2917, and other applicable confidentiality laws and regulations.**

**BH Provider Process:**

Submit a SHOUT Referral/Checklist form within 7 days of receiving the information regarding a suicide attempt that meets the criteria identified in the protocol.

 **Please send to:** **HCHHCACaseManagement@azblue.com**

**Completing the form:**

**Suicide Attempts**

Please ensure the date(s) and method(s) are completed.

**SHOUT Eligibility Criteria**

Please ensure the member meets the criteria prior to submitting the form. If you have any questions regarding the criteria, please BCBSAZ Health Choice Arizona Care Management team for assistance.

**Medical Intervention Occurred**

Medical intervention is defined as any procedure conducted on the patient to prevent further problems.

* Medical interventions - Any procedure to **fix** what is wrong. For example, but not limited to:
* Pumping the stomach
* IV or injectable medications
* Wound care
* Sutures for open wounds
* Inpatient hospitalization
* Surgery
* Dialysis
* Blood transfusion
* Procedures performed in order to evaluate **if** something is wrong are NOT considered medical interventions for SHOUT criteria. For example, but not limited to:
* Seeing the doctor
* Lab work
* X-rays, scans (CT, MRI, etc.)
* ED visit with no medical intervention
* Observation/monitoring in the ED
* EKG

**Behavioral Health Intervention(s) Occurred:**

Did any of the following interventions occur prior to, during, or after the crisis?

* Mobile crisis response
* Law enforcement involvement
* Psychiatric inpatient admission
* Court-ordered evaluation/treatment (COE/COT)
* Outpatient treatment
* Completion of ASAM (if applicable)
* Completion of CALOCUS (for children only)
* Other: Please describe.

**Follow-up Post-Attempt:**

* Was Crisis Prevention Plan updated after the attempt?
* Was the Individual Recovery Plan (IRP, formerly BHSP) updated after the attempt?
* Was the outpatient BH provider appointment scheduled? Please include the date.
* Was the prescriber (BHMP) appointment scheduled? Please include the date.
* Was the prescriber (Medical) appointment scheduled? Please include the date.