SUICIDE PREVENTION, ASSESSMENT, AND MANAGEMENT

SOP 116A-01

VA North Texas Health Care System
Dallas, TX 75216

Service Line(s):
Mental Health

Signatory Authority:
Stephen R. Holt, MD, MPH, MSNRS
Director

Effective Date:
November 24, 2020

Recertification Date:
November 24, 2025

Responsible Owner:
Service Chief, Mental Health

1. PURPOSE AND AUTHORITY

a. The purpose of this standard operating procedure (SOP) is to establish procedures on effective assessment, intervention, and management of Veterans with suicidality. This SOP must be followed by all VA North Texas Health Care System employees.

2. PROCEDURES

a. <u>Suicide Risk Identification Strategy:</u> A VANTHCS-wide suicide risk screening and evaluation protocol that encompasses suicide risk screening (Columbia Suicide Severity Rating Scale, C-SSRS) and a Comprehensive Suicide Risk Evaluation (CSRE).

b. **<u>Category I Patient Record Flag: High Risk for Suicide:</u>** Veterans will have a Category I Patient Record Flag: High Risk Flag for Suicide (HRF) added to their medical record within one business day by the Suicide Prevention Coordinator (SPC) after the determination that the Veteran is high risk for suicide based on review of the Comprehensive Suicide Risk Evaluation (CSRE), Suicide Behavior and Overdose Report (SBOR), and the Suicide Prevention Safety Plan (SPSP) that are to be completed by referring provide.

(1) Veterans flagged with HRF will be monitored and seen by Mental Health (MH) for at least 90 days after the flagging. The first month of the 90 days, the Veteran will receive four mental health visits. During the second and third month of the 90 days, the Veteran will receive, at the minimum, one visit each month. The CSRE and SPSP will be reviewed with the Veteran at the time the flag is placed and every 90 days after in conjunction with the HRF review.

(2) At the end of the 90 days from the initiation of the HRF, the HRF may be continued for an additional 30, 60, or 90 days, if clinically indicated. The Veteran will continue to receive monthly MH visits following the initial 90-day review. If the HRF is reviewed and discontinued, the frequency of Veteran/provider visits after removal of the HRF will be determined by the provider and be based on additional reported episodes of

self-directed violence, the Veteran's level of engagement, progress in the mental health recovery process, and persistence of reported symptoms.

(3) The use of the HRF is restricted to addressing immediate clinical safety issues. It is important to ensure that usage of HRF is limited to only Veterans at high risk and only for the duration of the increased risk.

c. **Suicide Behavior and Overdose Report (SBOR):** This will be completed by the provider (i.e., Nurse, Nurse Practitioner, Social Worker, Psychologist, Physician, Physician Assistant, Clinical Pharmacist, etc.) for all suicide attempts within the last 12 months, interrupted attempts, suicides, all events of undetermined intent, and all cases of suicidal ideation that result in the consideration of a HRF. Only one SBOR is needed per reported event. When a SBOR is completed CPRS automatically notifies the SPCs of the completed SBOR without the need for authors of the SBOR to add SPCs as co-signers.

d. **Suicide Prevention Safety Plan (SPSP):** A prioritized written list of coping strategies and resources developed with and continually available to Veterans who have been deemed to be at an elevated risk for suicide. This plan should be simple, easy to read, using the Veteran's own words, and should include warning signs for suicidal risk, internal coping strategies, social and/or family supports to contact, professional resources and/or agencies to contact for help, and what should be removed from the Veteran's environment to decrease access to means available for use in self-directed violent behaviors.

e. **Assessment, treatment planning, and intervention** are determined by the level of risk assessed according to the following:

(1) Acutely suicidal high-risk Veterans will be admitted as appropriate to a Mental Health Acute Inpatient Unit. A SBOR will be entered for any significant instance of self-directed violence, including previously undocumented suicide attempts within the last 12 months, interrupted attempts, all events of undetermined intent, and all cases of suicidal ideation that result in the consideration of a HRF that have not been previously reported via an SBOR. SPCs will review the Veteran's SBOR, CSRE, and SPSP for potential placement of a HRF.

(2) Discharge planning from a Mental Health Acute Inpatient Unit and a Mental Health Residential Rehabilitation Treatment Program (MHRRTP) for safety should include, but is not limited to:

(a) Updated CSRE within a week prior to discharge and C-SSRS (and updated CSRE if indicated) 24 hours before discharge.

(b) If the Veteran has an HRF, the Veteran will receive four outpatient MH visits.

(c) A completed SPSP for all Mental Health Acute Inpatient Veterans and for any clinically indicated MHRRTP Veterans prior to discharge to the outpatient level of care.

The SPSP will be documented in CPRS and the Veteran will be provided a printed copy.

(d) The Veteran will be given the telephone numbers of the Dallas VA Medical Center or the Mental Health Outpatient Clinic where the Veteran is assigned and the Veteran's Crisis Line (1-800-273-8255, Press 1). The Veteran will receive written instructions of follow-up appointments for continuity of care.

(e) Address Unplanned or Against Medical Advice discharges by alerting leadership, a scheduled follow-up within 24 hours of the unplanned discharge, or immediate follow-up for Veterans who discharge without notifying staff in accordance with VHA Directive 2010-052

f. Management of a Suicidal Veteran on a Non-Mental Health Inpatient Unit:

(1) In the event that a Veteran discloses that he/she experienced or is experiencing suicidal thoughts/behaviors/intent/plan or expresses significant emotional distress suggestive of a potential for increased risk for suicide while on a non-Mental Health inpatient unit, then non-Nursing staff who receive the disclosure initially need to maintain visual contact of Veteran and notify Nursing staff who will follow local Nursing policy (118A-02). For urgent or stat consults, staff are to also contact the Mental Health Consultation-Liaison Team. Staff will conduct an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and will take necessary action to minimize the risk (see Appendix A).

g. Management of Safety at an Outpatient Level of Care:

(1) If a Veteran presents in person to any staff member and discloses that he/she experienced or is experiencing suicidal thoughts/behaviors/intent/plan or expresses significant emotional distress, the staff will maintain visual contact with the Veteran, remain engaged with the Veteran and offer an assessment with Mental Health (MH). Staff will conduct an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and will take necessary action to minimize the risk (see Attachment A).

(2) If the Veteran agrees to an assessment by MH, then the Veteran will remain in continuous visual contact until there is a warm handoff to Mental Health. If MH is not available and accessible, the Veteran will be escorted to the Emergency Department (ED) or Primary Care Mental Health Integration (PCMHI) to receive an immediate assessment. The staff member escorting the Veteran will explain the urgency of the situation to the reception staff and remain with the Veteran until the Veteran is received by a provider within the program. The providers will determine the appropriate clinical course of action.

(3) If the Veteran refuses to meet with a Mental Health provider or leaves the area after disclosing suicidal thinking or other self-directed violence, the staff member will notify the VA and/or local Police. At the Dallas VAMC, Fort Worth Outpatient Clinic, Sam Rayburn Memorial Veterans Center, Polk Street Clinic, and Grand Prairie

Community-Based Outpatient Clinic (CBOC) staff will alert the VA Police. Local police should be notified if the occurrence transpires at the Denton, Decatur, Granbury, Greenville, Plano, Sherman, and Tyler CBOCs. VA and/or local police will provide assistance, as appropriate. In addition, the staff member will alert their direct supervisor. If the Veteran leaves the area and cannot be located, staff will alert VA and/or local Police. VA Police are unable to physically detain a suicidal Veteran without an Order of Protective Custody (OPC). A physician may initiate the process for an OPC. If local Police have been contacted by a VA employee and information is disclosed without the Veteran's consent due to safety concerns, the person who disclosed the information will need to account for that disclosure either electronically or through a Report of Contact that is to be sent to the Privacy Office.

(4) Veterans who are flagged with the HRF while at the outpatient level of care will have a CSRE and SPSP completed by a provider when seen by a Mental Health provider.

h. **Emergency Department (ED):** All Veterans presenting to the ED will be screened for suicidal risk. The Veteran will be evaluated for appropriate level of care by a Licensed Independent Practitioner (LIP). Any Veteran who presents to the ED with potentially suicidal ideation should be contained in an area with 1:1 observation by Nursing until further evaluation and disposition is made. A SBOR will be entered for any significant instances of self-directed violence, including previously undocumented suicide attempts within the last 12 months, interrupted attempts, all events of undetermined intent, and all cases of suicidal ideation that results in the consideration of a HRF that has not previously been reported via an SBOR. Veterans who are assessed as increased risk for suicide but determined safe to discharge back to the community from the ED will have a SPSP completed.

i. Outpatient: Veterans who present as not high acute suicide risk may be managed on an outpatient basis. The Suicide Risk Identification Strategy will be conducted as outlined by national standards.

(1) In order to identify Veterans at risk for suicide, a suicide risk screening will be conducted on all Veterans when shown as due in the clinical reminder system.

(2) For outpatient Mental Health services, a C-SSRS will be completed at time of intake.

(3) If positive, a CSRE will be completed on the same day by an LIP. A LIP is a MD, DO, Psychologist, LCSW (or equivalent or LMSW with co-signer), APN/NP, PA, Clinical Pharmacy Specialist, or other allied health care professionals who, by virtue of their educational and approved privileges and/or scope of practice have been determined by VANTHCS as privileged to diagnose and treat mental illness, or are trainees under the clinical supervision of the above listed disciplines with required co-signature of their documentation. If the Veteran is being escorted to MH, then it needs to be immediate. Under no circumstances will the Veteran be left alone during this hand-off process.

(4) Low or Intermediate: In the case of a Veteran determined to be of low or intermediate risk, the Veteran and his/her significant other will be provided contact instructions, including telephone numbers of how and whom to contact in case of an exacerbation of suicidal ideation or self-directed violence.

j. **Category I HRF:** All Veterans who have a HRF will receive an enhanced care plan. The enhanced care plan consists of four mental health visits during the first month of HRF and at least one appointment per month the second and third month of the 90-day period. At the end of 90 days, the Veteran will be assessed to determine if the HRF should be continued for an additional 30, 60, or 90 days or deactivated. If the HRF is continued an additional 90 days, MH will schedule, at a minimum, one mental health appointment per 30 days with the Veteran.

(1) Monitor Category I HRF: The SPC will monitor to ensure that Veterans who have a HRF are keeping their appointments. In the event of a no-show or missed appointment, the Veteran's provider will make a minimum of three attempts to contact the Veteran to reschedule the missed appointment. If the provider or the SPC think that the Veteran might be in imminent danger or at risk of self-harm, the VA Police will be contacted to request the initiation of a welfare check. In extenuating circumstances, the local Police may be contacted directly; however, the Privacy Office will need to be notified and an Accounting of Disclosure will need to be made. An extenuating circumstance might exist if there was a serious and imminent threat to the individual or the public, and if disclosing to Police would prevent or lessen the threat.

(2) Transfer Category I HRF: The SPC must assist any Veteran with a HRF who is moving to transfer care to the nearest VA facility and set up an initial appointment. This must include notification to the new site SPC about the Veteran's date of move, first appointment, new address, and other relevant information. If the Veteran does not show for the initial new-site appointment, outreach is the responsibility of the new site. Treatment providers and staff should alert SPCs when they are aware of Veterans with a HRF moving into or out of the VANTHCS catchment area.

k. **On-Campus Suicide Event:** Should a death by suicide or attempted suicide occur on station, the area will be secured with any evidence and VA Police notified. Staff debriefing assistance is available for staff troubled by a suicide of a Veteran through the Employee Assistance Program (EAP).

l. **Veterans Crisis Line:** All suicidal crisis calls will be handled through the Veteran's Crisis Line (VCL). The following procedure will be followed:

(1) When a Veteran calls VANTHCS and verbalizes suicidal ideation or is in a suicidal crisis, the call will be warmly transferred to the Veteran's Crisis Line, (800) 273-8255, Press 1.

(2) Before transferring the call, the staff member will try to obtain the name, telephone number, last four of the Veteran's social security number, address, and

current physical location. The staff member transferring the Veteran to the VCL will explain to the Veteran that they are being transferred to the VCL to obtain help for them.

(3) “warm transfer” means that the VANTHCS staff will transfer the Veteran to the VCL and give the VCL staff the Veteran's name, telephone number, last four of the Veteran’s social security number, address and/or current physical location.

(4) The Suicide Prevention team will follow-up on the call per established Veteran's Crisis Line protocol.

3. ASSIGNMENT OF RESPONSIBILITIES

a. **Chief of Staff.** The Chief of Staff is responsible for assuring compliance with this policy and ensuring staff knowledge of environmental risk assessment.

b. **Service Chiefs or Designees.** The Service Chiefs or Designees are responsible for ensuring that employees receive training on the recognition, management, and reporting of suicidal behavior/events.

c. Suicide Prevention Team. The Suicide Prevention Team has the responsibility to facilitate implementation and maintenance of suicide prevention strategies within the medical center, the outpatient clinics, and the CBOCs to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran population. The Suicide Prevention team, in collaboration with care teams and service providers, are charged with the following:

(1) Conduct reviews of all SBORs.

(2) Design, recommend, conduct, and promote educational programs to assist medical center staff to improve skills in preventing and managing suicidal behavior.

(3) Collect, trend and report data regarding suicidal events.

(4) Recommend actions to improve the medical center's ability to prevent and manage suicidal behavior.

(5) Track and report the status of actions taken in response to suicidal events.

(6) Control the Category I Patient Record Flag as it relates to high risk for suicide. The SPC limits the use of this flag to Veterans who meet the criteria for placement on this list. The SPC reviews the HRF in collaboration with the providers at the end of 90 days to determine if the Veteran continues to meet criteria for the flag.

(7) Participates in individual Root Cause Analysis (RCA) and aggregate reviews concerning Veterans who have attempted or completed a suicide as required.

(8) Participates in Mental Health Environment of Care rounds to ensure compliance with safety standards developed by the National Center for Patient Safety.

(9) Establish relationships with local and state organizations to promote education and awareness of suicide prevention strategies.

(10) Develop partnerships with Transition and Care Management Coordinators, Patient Safety Managers (PSM), Health Care for Homeless Veterans (HCHV) Coordinators, local Vet Center staff, residential care teams, and local mental health teams. This partnership is to assure that teams, and local mental health teams. This partnership is to assure that Veterans are assessed and evaluated for suicide risk.

(11) After a Veteran is identified as High Risk, the SPC will monitor the HRF to ensure treatment compliance.

(12) The Suicide Prevention team is responsible for following up on all calls from the Veteran's Crisis Line to ensure timely access to care for Veterans in crisis.

(13) The Suicide Prevention team is responsible for staff and Veteran education during Suicide Prevention Awareness Month.

d. **All employees.** All employees are responsible for adhering to this policy.

4. DEFINITIONS

a. **Self-Directed Violence (SDV) Classification System.** For the purpose of documentation and reporting, the following standardized nomenclature for suicide-related thoughts and behaviors will be utilized. The uniform definitions for Self-directed Violence Classification System (SDVCS) were developed by the Centers for Disease Control and Prevention (CDC), Department of Veterans Affairs (VA) and Department of Defense (DoD). A Clinical Tool using SDVCS has been developed by the Veterans Integrated Service Network 19 Mental Illness Research Education and Clinical Center (VISN 19 MIRECC). Use of the SDVCS definitions for behavior that is self-directed and deliberately results in injury or the potential for injury to oneself will allow for specific recommendations for care at each determined point of classification, as well as communication concerning risk levels and care interventions among VA providers.

b. **Non-Suicidal Self-Directed Violence Ideation.** Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent.

c. **Suicidal Ideation.** Thoughts of engaging in suicide-related behavior.

d. **Self-Directed Violence.** Behavior that is self-directed and deliberately results in injury or potential for injury to oneself.

e. **Non-Suicidal Self-Directed Violence.** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent.

f. **Undetermined Self-Directed Violence.** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based on the available evidence.

g. **Suicidal Self-Directed Violence.** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

h. **Suicide Attempt.** A non-fatal, self-inflicted, potentially injurious behavior with any intent to die as a result of the behavior.

i. **Suicide**. Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior.

j. **Suicidal Intent.** There is past or present evidence (explicit and/or implicit) that at the time of injury the individual intended to kill self and wished to die and that the individual understood the probable consequences of his or her actions.

k. **Preparatory Behavior.** Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).

l. **Physical Injury.** A (suspected) bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts of rates that exceed the threshold of physiological tolerance. In some cases, an injury results from an insufficiency of vital elements, such as oxygen. Acute poisonings and toxic effects including overdoses of substance and wrong substances given or taken in error are included, as are adverse effects and complications of therapeutic, surgical, and medical care. Psychologist injury is excluded in this context.

5. REFERENCES

a. Self-Directed Violence (SDV) Classification System Clinical Tool, Centers for Disease Control and Prevention, https://www.mirecc.va.gov/visn19/docs/SDVCS.pdf

b. Suicide Prevention Coordinator (SPC) Guide, June 19, 2014, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Admin%20Items/SPC%20Manual/SPC%20Manual%20June%2015%202015.pdf

c. High Risk for Suicide Patient Record Flag Changes, October 3, 2017, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2017M/2017.10.03_M_High%20Risk%20for%20Suicide%20Patient%20Record%20Flag%20Changes.pdf

d. Eliminating Veteran Suicide Implementation of Suicide Risk Screening & Evaluation, November 5, 2018, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2018M/2018.11.02_M_Eliminating%20Veteran%20Suicide%20Implementation%20of%20Suicide%20Risk%20Screening%20and%20Evaluation.pdf

e. Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Programs (RRTP) Discharge Planning and Follow-up, June 12, 2017, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2017M/2017.06.12_M_Eliminating%20Veteran%20Suicide%20Enhancing%20Acute%20Inpatient%20Mental%20Health%20and%20Residential%20Rehabilitation%20Treatment%20Program%20RRTP%20Discharge%20Planning%20and%20Followup.pdf

f. Suicide Prevention in Emergency Departments (SPED): Suicide Safety Planning and Follow Up Interventions, September 7, 2018, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2018M/2018.09.07_M_Suicide%20Prevention%20in%20Emergency%20Departments%20(SPED)_Suicide%20Safety%20Planning%20and%20Follow%20Up%20Interventions.pdf

g. Guidance on Patients Failure to Attend Appointments (No Shows), August 6, 2013, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2020M/2020.01.16_M_%20Update%20to%20High%20Risk%20for%20Suicide%20Patient%20Record%20Flag%20Changes.pdf

h. Suicide Awareness Training, April 11, 2017, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2017M/2017.04.11_M_Suicide%20Awareness%20Training%20Memorandum.pdf

i. Suicide Prevention Safety Plan National CPRS Note Templates Implementation, June 1, 2018, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2018M/2018.06.01_M_Suicide%20Prevention%20Safety%20Plan%20National%20CPRS%20Note%20Templates%20Implementation.pdf

j. Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation, April 8, 2019, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2019M/2019.04.08_M_Suicide%20Behavior%20and%20Overdose%20Report%20%20Computerized%20Patient%20Record%20System%20Note%20Template%20Implementation.pdf

k. Update to High Risk for Suicide Patient Record Flags, January 16, 2020, https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Memos/2020M/2020.01.16_M_%20Update%20to%20High%20Risk%20for%20Suicide%20Patient%20Record%20Flag%20Changes.pdf

6. REVIEW

This SOP will be reviewed at minimum prior to recertification and including when there are changes needing to be made to the document as required by national policy or a health care accreditation body mandate.

7. RECERTIFICATION

This SOP is scheduled for recertification on or before the last working day of May 2025. In the event of contradiction with national policy, the national policy supersedes and controls.

8. SIGNATORY AUTHORITY

Stephen R Holt 233799

Digitally signed by Stephen R Holt 233799
Date: 2020.11.25 07:08:50 -06'00'

Stephen R. Holt, MD, MPH, MSNRS
Director
Date Approved: November 24, 2020

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

DISTRIBUTION: The SOP will be sent out to the NTX Users and NTX Users1 email group on an annual basis. It will also be posted on the Director's SharePoint page as well as the Mental Health SharePoint page.

SUICIDE ENVIRONMENTAL RISK ASSESSMENT PATIENT/EXAM ROOM CHECKLIST

All patient/exam rooms pose a risk when caring for suicidal patients. We can mitigate the risk by removing objects (when possible) that have the potential for self-harm **without** adversely affecting medical care.
** Emergency equipment: oxygen flowmeters, Ambu bag, suction equipment and tubing should NOT be removed from patient rooms**

	Arrival	**1st Shift**	**2nd shift**	**3rd shift**
Remove from the patient care area when possible:	Initials	Initials	Initials	Initials
1. Supply Carts				
2. Plastic garbage bags/garbage cans. Replace all plastic garbage bags with paper bags or use paper garbage cans.				
3. Linen carts/bags; biohazard bins; and sharps containers, if possible				
4. Blood Pressure Cuffs, boxes of gloves				
5. Hand sanitizer/alcohol/soap containers, if possible				
6. Cleaning products (i.e., Caviwipes, etc.)				
7. Extra furniture (chairs, stools, fan, bed-side tables, etc.)				
8. Ensure that all cabinets and drawers are locked				
9. Oxygen tanks stored under bed/stretcher, if applicable.				
10. Non-medically necessary oxygen tubing and supplies				
11. Hangers in closet				
12. Loose items that can potentially cause harm (telephone, keyboards, etc.)				
13. Items on top of bedside cart				
14. All extra linen				
15. Equipment cords (shorten to 12 inches or less)				
16. Pajamas with drawstrings-use pajamas with snaps only. If you need to use hospital gowns cut the ties off				
17. Walkers/Wheelchairs/Canes				
18. Any hospital meal trays, glassware, silverware or cans.				
19. Inventory all patient belongings, place in personal belongings bag and secure belongings outside of the room.				
20. All patient possessions to remain out of patient access				
Patient may keep the following:				
1. Dentures/partials				
2. Prescription eyeglasses or contacts				
3. Hearing Aids				
4. Prosthetics and ambulatory devices at the discretion of the provider				

Note: This list is not all inclusive and does not indicate that items listed must be removed if needed for patient care.

Signature	**Initials**	**Signature**	**Initials**	**Signature**	**Initials**

Room Number

Date_____