

Army Suicide Event Report 2006 ASER

Version: 2.2.1 (29-Dec-2005)
Previous editions are obsolete.

The ASER was developed to standardize the data collected on all suicide behaviors among Army soldiers. Completed suicide is one of the leading causes of death among U.S. soldiers, and suicide behaviors lead to unnecessary soldier and family suffering and premature attrition. The ASER is an integral part of the Army's Suicide Prevention Program.

The ASER should be completed for all fatalities, hospitalizations, and evacuations where the injury or injurious intent is self-directed. It is not intended to replace the psychological autopsy, which is limited to fatalities in which the manner of death is uncertain.

Instructions:

The ASER is REQUIRED for:

- All suicide behaviors that resulted in hospitalization or evacuation.
- All suicide completions/fatalities.

This form must be completed by a credentialed behavioral health (BH) clinician (psychologist, psychiatrist, social worker, or psychiatric nurse) within 30 days of the date of hospitalization or evacuation, or within 60 days of the date the event was determined to be a suicide. All answers should reflect the circumstances at the time of the event.

The preferred method of entry for the ASER is via the web form available at <https://aser.amedd.army.mil>. If the web form is inaccessible, this Microsoft Word form may be used. Word forms have known problems with "Reading Layout" and should be completed in "Print Layout". To activate this mode, select "View" from the menu bar at the top of the screen and choose the "Print Layout" menu item.

Please respond to all questions by typing in the text fields and clicking on the checkboxes. If you are unable to find an answer, respond with "don't know". Use the "File" menu-item "Save As" to save the form to a new file name. Email the completed form to suicide.reporting@us.army.mil using AKO web mail to guarantee a secure email environment. If electronic completion is impossible, this form may be completed by hand and faxed to 253-968-3731.

For suicide behaviors that resulted in hospitalization or evacuation:

1. Information is primarily obtained from the patient
2. Review all available medical and behavioral health records
3. Interview co-workers and supervisors as needed

For suicide completions/fatalities:

1. Review all available records:
 - Medical and mental health records
 - Personnel and counseling records
 - Responsible investigative agency (e.g. CID) records
 - Records related to manner of death, such as casualty reports, toxicology/lab reports, pathology/autopsy reports, suicide notes, etc.
2. Interview related persons:
 - Co-workers and supervisors
 - Responsible investigative agency officer
 - Involved professionals, such as physicians, behavioral health clinicians, drug and alcohol counselors, chaplains, military police, family service personnel (e.g. ACS), etc.
 - Interviews with family members are encouraged but not required, and should only be done with the utmost sensitivity. The purpose of these interviews is to provide firsthand data concerning the decedent and his/her behavior, not to determine accountability or culpability for the decedent's death.

Privacy:

HIPAA: This document may contain confidential protected health information (PHI) and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited.

Freedom of Information Act (FOIA): Personally identifying information in this document is protected under FOIA exemption 6 (5 U.S.C. (b)(6)). Release of information in this document to satisfy FOIA requests is limited to aggregate and non-personally identifiable data. Reports that satisfy these requirements are published by the Suicide Risk Management and Surveillance Office (SRMSO). Email suicide.reporting@us.army.mil or visit <https://aser.amedd.army.mil> for more information.

Email any questions or concerns to: suicide.reporting@us.army.mil

PROTECTED HEALTH INFORMATION (PHI)

RETAIN THIS COVER PAGE AS A PRIVACY MEASURE

I. Event Information

1. Event date:	_____ (dd-mmm-yy)
Event time:	_____ (local time, hhmm)
<hr/>	
2. Geographic location of event:	
Country:	_____
State (or equivalent):	_____
City, post, or camp:	_____
<hr/>	
3. Event setting:	<input type="checkbox"/> Residence (own) <input type="checkbox"/> Residence of friend or family <input type="checkbox"/> Work/jobsite <input type="checkbox"/> Automobile (away from residence) <input type="checkbox"/> Inpatient medical facility <input type="checkbox"/> Other: _____
<hr/>	
4. Type of event: (check all that apply)	<input type="checkbox"/> Completed suicide <input type="checkbox"/> Hospitalization (inpatient) <input type="checkbox"/> Evacuation <input type="checkbox"/> Other: _____
<hr/>	
If hospitalized, what types of facilities were involved? (check all that apply)	<input type="checkbox"/> Military Treatment Facility <input type="checkbox"/> Civilian facility <input type="checkbox"/> VA hospital <input type="checkbox"/> Don't know
List the facility name(s):	_____
Start date of hospitalization?	_____ (dd-mmm-yy)
	<input type="checkbox"/> Check if unknown
End date of hospitalization?	_____ (dd-mmm-yy)
	<input type="checkbox"/> Check if unknown
	<input type="checkbox"/> Check if patient is still in the inpatient facility
<hr/>	
5. Primary method used:	<input type="checkbox"/> Overdose (medication, drugs, or alcohol) <input type="checkbox"/> Poisoning by solid or liquid substance (not medication) <input type="checkbox"/> Poisoning by vehicle exhaust <input type="checkbox"/> Poisoning by utility gas <input type="checkbox"/> Firearm / gun, military issue or duty weapon <input type="checkbox"/> Firearm / gun, other than military issue <input type="checkbox"/> Jumping from high place <input type="checkbox"/> Motor vehicle crash <input type="checkbox"/> Hanging, strangulation, or suffocation <input type="checkbox"/> Cutting or piercing instrument <input type="checkbox"/> Submersion / drowning <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't know
<hr/>	
6. During the event, was alcohol used?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<hr/>	

I. Event Information (continued)

7. During the event, were drugs used?
- Yes
 No
 Don't know

If yes, what types of drugs were used?	Overdose	Used, no overdose	Were not used
Drugs (illicit/illegal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-prescription medications (e.g. over-the-counter medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Is there evidence that the patient/decedent intended to die?
- Yes
 No
 Don't know

9. Was the method used (and quantity, if appropriate) one that is typically lethal?
- Yes
 No
 Don't know

10. Is there evidence the event involved death-risk gambling? (e.g. Russian roulette, walking railroad tracks, playing "chicken")
- Yes
 No
 Don't know

11. Is there evidence that the event was planned and/or premeditated?
- Yes
 No
 Don't know

12. Was the event performed under circumstances where it would likely be observed and intervened in by others?
- Yes
 No
 Don't know

13. Was a suicide note left?
- Yes
 No
 Don't know

14. Prior to the event, did the patient/decedent communicate potential for self-harm?
- Yes
 No
 Don't know

If yes, how?
(check all that apply)

- Written
 Verbal
 Other: _____

To whom?
(check all that apply)

- Supervisor
 Chaplain
 Mental health staff
 Friend
 Spouse or significant other
 Other: _____

I. Event Information (continued)

15. What was the patient/
decedent's primary motivation
for performing this event?
(select only one)

- Emotion relief (e.g. to stop bad feelings, self-hatred, anxiety relief)
- Interpersonal influence (e.g. to get help, get attention, shock others)
- Feeling generation (e.g. to stop feeling numb)
- Avoidance/escape (e.g. to avoid or escape deployment, prevent being hurt in other ways)
- Individual reasons (e.g. self-punishment, to express anger, be with deceased loved one)
- Hopelessness (e.g. pessimistic regarding future)
- Depression (e.g. chronic or severe clinically depressed mood)
- Other psychiatric symptoms (e.g. PTSD, psychotic)
- Impulsivity (e.g. due to substance abuse, personality characteristics)
- Other: _____
- Don't know

16. Duty environment/status at time
of event:
(check all that apply)

- Garrison
- Leave
- TDY/TAD
- AWOL
- Deployed
- Training
- Psychiatric hospitalization
- Medical hold
- In evacuation chain
- Under command observation (e.g. CIP)
- Other: _____

17. Was the event related to a
deployment?

- Yes
- No
- Don't know

If yes, what type of
deployment(s)?
(check all that apply)

- Anticipated deployment
- Current deployment
- Prior deployment

II. Patient/Decedent Personal Information

18. Last name:	_____	
First name & middle initial:	_____/_____	
Social Security Number:	_____	
19. Date of birth:	_____ (dd-mmm-yy)	
20. Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Don't know	
21. Relationship to sponsor:	<input type="checkbox"/> Sponsor <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	
22. Racial category: (check only one)	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't know	
23. Specific ethnic group: (check only one)	<u>Hispanic</u> <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Latin American <input type="checkbox"/> Other Spanish <u>Native American</u> <input type="checkbox"/> Aleut <input type="checkbox"/> Eskimo <input type="checkbox"/> U.S./Canadian Indian Tribes <input type="checkbox"/> Other <input type="checkbox"/> Don't know	<u>Asian</u> <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <u>Pacific Islander</u> <input type="checkbox"/> Melanesian <input type="checkbox"/> Polynesian <input type="checkbox"/> Other Pacific Islands
24. Marital status: (check only one)	<input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Legally separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Don't know	
If married,	<input type="checkbox"/> Resides with spouse <input type="checkbox"/> Separated due to relationship issues <input type="checkbox"/> Separated for reasons other than relationship (e.g. deployed) <input type="checkbox"/> Don't know	

II. Patient/Decedent Personal Information (continued)

25. Education:
- Some high school, did not graduate
 - GED
 - High school graduate
 - Some college or technical school, no degree or certificate
 - College degree of less than four years or technical school certificate
 - Four-year college degree
 - Master's degree or greater
 - Don't know
-
26. Residence at the time of event:
- Barracks, tents, or other shared military living environment
 - Non-military shared living environment
 - BEQ or BOQ
 - On-post family housing
 - Off-post family housing
 - Other: _____
 - Don't know
-
27. Did the patient/decedent reside alone at the time of the event?
- Yes
 - No
 - Don't know
-
28. Did the patient/decedent have minor children?
- Yes
 - No
 - Don't know
- If yes, were the children residing with him/her?
- Yes
 - No
 - Don't know

III. Sponsor's Military Information

29. Service:	<input type="checkbox"/> Army	<input type="checkbox"/> Coast Guard			
	<input type="checkbox"/> Navy	<input type="checkbox"/> Foreign military			
	<input type="checkbox"/> Air Force	<input type="checkbox"/> Other uniformed service			
	<input type="checkbox"/> Marines	<input type="checkbox"/> Other: _____			
30. Component/Military status:	<input type="checkbox"/> Regular (e.g. Army, Air Force)				
	<input type="checkbox"/> Reserve (e.g. USAR, USMCR)				
	<input type="checkbox"/> National Guard				
	<input type="checkbox"/> Other: _____				
31. Job code: (MOS, SSI, AFSC, DAFSC, or other military job code)	_____				
32. Duty status: (check all that apply)	<input type="checkbox"/> Active Duty				
	<input type="checkbox"/> AGR (Active Guard/Reserve)				
	<input type="checkbox"/> IET (Basic and Advanced Individualized Training)				
	<input type="checkbox"/> Mobilized RC (Reserve and National Guard)				
	<input type="checkbox"/> ADT (Active Duty for Training)				
	<input type="checkbox"/> IDT (Weekend Reserve Drill)				
	<input type="checkbox"/> Retired				
	<input type="checkbox"/> Released from active duty within 120 days				
	<input type="checkbox"/> Other: _____				
	<input type="checkbox"/> Does not apply				
33. Pay grade:	<input type="checkbox"/> E1	<input type="checkbox"/> E6	<input type="checkbox"/> W1	<input type="checkbox"/> O1	<input type="checkbox"/> O6
	<input type="checkbox"/> E2	<input type="checkbox"/> E7	<input type="checkbox"/> W2	<input type="checkbox"/> O2	<input type="checkbox"/> O7
	<input type="checkbox"/> E3	<input type="checkbox"/> E8	<input type="checkbox"/> W3	<input type="checkbox"/> O3	<input type="checkbox"/> O8
	<input type="checkbox"/> E4	<input type="checkbox"/> E9	<input type="checkbox"/> W4	<input type="checkbox"/> O4	<input type="checkbox"/> O9
	<input type="checkbox"/> E5		<input type="checkbox"/> W5	<input type="checkbox"/> O5	<input type="checkbox"/> O10
	<input type="checkbox"/> Cadet/Midshipman				
	<input type="checkbox"/> Does not apply				
34. Permanent duty station / command location	<input type="checkbox"/> Same as geographic event location				
	<input type="checkbox"/> Other location				
If other location,					
Country: _____					
State (or equivalent): _____					
City, post, or camp: _____					
35. Permanent duty assignment:					
Division:	_____				
Brigade:	_____				
Battalion:	_____				
Company:	_____				
36. UIC or other unit identification:	_____				
37. Length of time in unit:	__ years, __ months <input type="checkbox"/> Check if unknown				

IV. History

Was the patient/decedent seen by...	Yes	No	Don't know	If yes, how long prior to event? (select most recent occurrence)			
				Within 30 days	Within 3 months	Within 1 year	Over 1 year ago
38. ...a Medical Treatment Facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. ...Substance Abuse Services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. ...a Family Advocacy Program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. ...Chaplain services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. ... <u>Outpatient</u> Mental Health? (including deployment mental health services)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. ... <u>Inpatient</u> Mental Health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had the patient/decedent...							
44. ...been diagnosed with any Mood Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. ...been diagnosed with a Bipolar Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. ...been diagnosed with Major Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. ...been diagnosed with a Psychotic Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. ...been diagnosed with PTSD?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. ...been diagnosed with an Anxiety Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. ...been diagnosed with a Personality Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. ...had a history of Substance Abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, select all that apply:				Dependence	Abuse		
Alcohol				<input type="checkbox"/>	<input type="checkbox"/>		
Drugs (illicit/illegal)				<input type="checkbox"/>	<input type="checkbox"/>		
Prescription medications				<input type="checkbox"/>	<input type="checkbox"/>		
Non-prescription medications (e.g. over-the-counter medication)				<input type="checkbox"/>	<input type="checkbox"/>		
52. ...taken psychotropic medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. ...had prior self-injurious events?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many prior events?				<input type="checkbox"/> One prior event <input type="checkbox"/> More than one prior event			
Was this event similar to prior event(s)?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know			
Age at first self-injurious event:							

IV. History (continued)

Was the patient/decedent the subject of...	Yes	No	Don't know	If yes, how long prior to event? (select most recent occurrence)			
				Within 30 days	Within 3 months	Within 1 year	Over 1 year ago
54. ...Courts Martial proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. ...Article 15 proceedings or civilian criminal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. ...Administrative Separation proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. ...AWOL or desertion proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. ...a Medical Evaluation Board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. ...civil legal problems? (e.g. child custody dispute, litigation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. ...non-selection for advanced schooling, promotion, or command?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient/decedent an alleged or confirmed VICTIM of...							
61. ...physical abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. ...sexual abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. ...emotional abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. ...sexual harassment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient/decedent an alleged or confirmed PERPETRATOR of...							
65. ...physical abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. ...sexual abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. ...emotional abuse or assault?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. ...sexual harassment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. History (continued)

69. List the three most recent deployments, if any, including current deployments:

Deployment location 1: Afghanistan Kosovo
 Iraq Other Europe
 Kuwait North America
 Korea Central or South America
 Other: _____

Deployment start date: _____ (dd-mmm-yy)

Deployment end date: _____ (dd-mmm-yy)
 (or expected end date)

Deployment location 2: Afghanistan Kosovo
 Iraq Other Europe
 Kuwait North America
 Korea Central or South America
 Other: _____

Deployment start date: _____ (dd-mmm-yy)

Deployment end date: _____ (dd-mmm-yy)
 (or expected end date)

Deployment location 3: Afghanistan Kosovo
 Iraq Other Europe
 Kuwait North America
 Korea Central or South America
 Other: _____

Deployment start date: _____ (dd-mmm-yy)

Deployment end date: _____ (dd-mmm-yy)
 (or expected end date)

	Yes	No	Don't know	If yes, how long prior to event? (select most recent occurrence)			
				Within 30 days	Within 3 months	Within 1 year	Over 1 year ago
70. Did the patient/decendent experience direct combat operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, did the patient/decendent... and his/her unit engage in battle resulting in casualties/wounded?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... become wounded or injured in combat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... personally witness a unit member, ally, enemy, or civilian being seriously wounded or killed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... see the bodies of dead soldiers or civilians following battle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
... kill others in combat (or have reason to believe others were killed as result of actions)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. History (continued)

Was there evidence of...	Yes	No	Don't know	If yes, how long prior to event? (select most recent occurrence)			
				Within 30 days	Within 3 months	Within 1 year	Over 1 year ago
71. ...a failed or failing spousal or intimate partner relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
72. ...a failed or failing other relationship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
73. ...a completed spousal suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
74. ...a completed family member suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75. ...a completed suicide by a friend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76. ...a death of spouse or family member? (other than suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
77. ...a death of a friend? (other than suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
78. ...a physical health problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
79. ...a chronic spousal or family severe illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80. ...excessive debt or bankruptcy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
81. ...job problems? (e.g. laid off, fired, excessive pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
82. ...supervisor or coworker issues or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
83. ...a poor work performance review or evaluation? (e.g. bar for reenlistment, flagged record, extra duty imposed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
84. ...unit or workplace hazing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Don't know				
85. Did the patient/decedent have a family history of mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
86. Was there a gun in the home or immediate environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

V. Narrative Summary

Personally identifying information in the narrative summary is protected by HIPAA and FOIA exemption 6 (5 U.S.C. (b)(6)).

87. Describe any details of the circumstances that led to the suicide attempt/completion that have not already been captured by this form.

88. Provide a brief "bio-psycho-social" formulation as to WHY this patient/decedent engaged in suicidal behavior. (optional)

89. Identify any additional risk management issues associated with this case.

VI. ASER Completion Information

90. Today's date: _____ (dd-mmm-yy)

91. Location where this ASER was completed: Same as geographic event location
 Other location

If other location,

Country: _____

State (or equivalent): _____

City, post, or camp: _____

92. Medical facility where this ASER was completed or supporting MTF: (use standard acronym, e.g. WRAMC) _____

93. Behavioral Health provider:

Name: _____

Rank/grade: _____

SSN: _____

Phone number: _____

DSN prefix: _____

Email: _____

Specialty:

Psychologist

Psychiatrist

Social Worker

Psychiatric Nurse

Licensed Mental Health Counselor or equivalent

Other: _____

94. Form completer, if not Behavioral Health provider:

Name: _____

Rank/grade: _____

SSN: _____

Phone number: _____

DSN prefix: _____

Email: _____

95. Comments: