

# Adolescent Suicide Attempt Report

## Zero Attempts

1. Name of hospital \_\_\_\_\_
2. Hospital county \_\_\_\_\_
3. During (*Month/Year*) \_\_\_\_\_/\_\_\_\_\_, no youth 17 or younger was treated here for a suicide attempt.

*ORS 441.750 states that Any hospital which treats as a patient a person under 18 years of age because the person has attempted to commit suicide: ... Shall report statistical information to the Department of Human Services about that person...."*

<b>Contact Person at this Facility</b> <i>Please print</i>	
Name	_____
Title	_____
Department	_____
Telephone	_____

*Fax this form to the number below no later than the 15th of the month following any month in which there were no youths treated at your hospital for a suicide attempt.*

Fax: 971-673-0990

Adolescent Suicide Attempt Data System  
Injury and Violence Prevention Program  
800 NE Oregon Street, Suite 772  
Portland, Oregon 97232  
Telephone: 971-673-1033