Survey of Suicidal Patients in Tochigi Prefecture
Questionnaire about Facility

Name of Facility: _____

Person filling out the form

Name: _____

Title: _____

Occupation 1. Physician 2. Nurse 3. Administrative Staff
4. Other _____

Phone number: _____ — _____ — _____ (Extension : _____)

Total number of beds in your facility: (_____) Beds

Does your facility have a psychiatric department? If so, please answer additional questions.
For part-time psychiatrists, please enter the full-time equivalent.

1. Yes 2. No psychiatric department

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Number of psychiatrists

Full time: (_____) persons
Part time: (_____) persons [Full time equivalent]

Number of psychiatric beds: (_____) beds

On call psychiatrist present: 1. Yes 2. No

Please select the type of ED facility: 1. Secondary 2. Tertiary

For the following questions, please enter the number of ED visits September 1st and September 30th, 2009.
If the same patient visited multiple times, please count them as multiple visits.

A total number of visits during the month of September 2009: (_____) visits

A total number of visits by suicidal patients: (_____) visits

For each visit by suicidal patients, please proceed to questionnaire about patients.

If you have comments or suggestions about suicide prevention or about coordination of care between emergency departments and psychiatric departments, please describe below.

Please return this this questionnaire by October 16th, 2009 using the enclosed envelope.
Even if you did not have a suicidal patient visit at your facility, please return the form.
Thank you for your participation.

Jichi University Department of Epidemiology
Yosikazu Nakamura, MD, PhD, MPH