In the Iowa District Court for _____ County
County where Application is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Application Alleging Serious Mental Impairment** Iowa Code § 229.6

1. I, _____, allege Respondent is suffering from
Full name: first, middle, last
serious mental impairment.

2. In support of this Application, I state:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

3. Based on the above facts, I believe Respondent is a danger to self or others and lacks judgmental capacity due to serious mental impairment. ☐ Yes ☐ No

4. I request that:
Check one

A. ☐ Respondent be taken into immediate custody.

B. ☐ Respondent not be taken into immediate custody.

5. In support of this Application, I have attached:
Check all that apply

A. ☐ A written statement of a licensed physician or mental health professional.

B. ☐ One or more Affidavits corroborating these allegations. *See Rule 12.36—Form 2.*

C. ☐ Corroborative information obtained and reduced to writing by the clerk or the clerk's designee. ***NOTE:*** *This option is only available when circumstances make it infeasible to obtain, or when the clerk considers it appropriate to supplement, the information under either subparagraph* ***5****(A) or* ***5****(B).*

Continued on next page

6. Attorney Help

Check one

A. ☐ An attorney did not help me prepare or fill in this paper.

B. ☐ An attorney helped me prepare or fill in this paper *If you check* B, *you must fill in the following information*:

_____ _____
Name of attorney or organization, if any *Attorney's PIN – Ask the attorney*

_____ _____ _____ _____
Business address of attorney or organization *City* *State* *ZIP code*

(____) _____ _____
Attorney's phone number *Attorney's email address – optional*

7. Oath and signature of applicant

I, _____, have read this Application, and I certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information provided in this Application is true and correct.

_____ _____, 20____ _____
Month *Day* *Year* *Applicant's signature**

_____ _____, _____ _____
Mailing address *City* *State* *ZIP code*

(____) _____ _____ _____
Phone number *Email address* *Additional email address, if applicable*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

Rule 12.36—Form 2: ***Affidavit in Support of Application Alleging Serious Mental Impairment***

In the Iowa District Court for _____ County
County where Affidavit is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Affidavit in Support of Application Alleging Serious Mental Impairment** Iowa Code § 229.6

I, _____, state that I am acquainted with Respondent who resides at
Full name: first, middle, last

_____ _____, _____, _____ _____,
Street address *City* *County* *State* *ZIP code*

and I believe Respondent is seriously mentally impaired. In support of this belief, I state:

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Oath and signature

I, _____, have read this Affidavit, and I certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information in this Affidavit is true and correct.

_____ _____, 20___ _____
Month *Day* *Year* *Affiant's signature**

_____ _____, _____ _____
Mailing address *City* *State* *ZIP code*

(_____) _____ _____ _____
Phone number *Email address* *Additional email address, if applicable*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Application is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Application for Appointment of Counsel and Financial Statement**

1. I, _____, state that I am:
Print your full name: first, middle, last

Check one

☐ Respondent

☐ Respondent's spouse

☐ Next friend of Respondent

☐ Guardian of Respondent

I request the court appoint counsel to represent Respondent at public expense because Respondent is financially unable to employ counsel.

2. Respondent's information

A. _____
Respondent's full name: first, middle, last

_____ _____, _____ _____
Street address *City* *State* *ZIP code*

_____ _____
Marital status *Number of dependents*

B. Respondent's age: _____.

C. Is Respondent currently in custody? ☐ Yes ☐ No

D. Respondent's employment status:

☐ Full-time

☐ Part-time (approximate hours per week:_____)

☐ Unemployed

Continued on next page

3. Respondent's income

A. Income Respondent currently receives before taxes and deductions:

**How often received?*
W = Weekly B = Bi-weekly (every other week) M = Monthly Y = Yearly

Average current income for Respondent	**Income**	
	How often received?* *W, B, M, Y*	**Amount**
(1) Wages from employer *Employer name:* *Job title:*		$
(2) Wages from employer *Employer name:* *Job title:*		$
(3) Unemployment assistance		$
(4) Family Investment Program		$
(5) Social Security		$
(6) Other *Identify:*		$
(7) Other *Identify:*		$
(8) Other *Identify:*		$
(9) Totals from attached pages, if any ☐ *Check this box if you attached additional pages regarding income sources.*		$
Total *Total income received by Respondent*		**$**

B. Total income from the past 12 months from any source, before taxes and deductions:

$_____

C. Is Respondent's spouse working? ☐ Yes ☐ No

If yes, spouse's wages before taxes and deductions: $_____

per: ☐ hour ☐ month ☐ year

Continued on next page

4. Respondent's assets

A. Real estate

Type of real estate	**Jointly owned?**	**Market value** *What it would sell for*	**Debt** *Total amount owed on debt* **and to whom owed**	**Net value** *Market value minus debt owed*
(1) Homestead *Address*	☐	$	$ to:	$
(2) Other real estate *Address*	☐	$	$ to:	$

☐ *Check this box if you have attached additional pages.*

B. Vehicles (includes cars, trucks, motorcycles, boats, and other motorized vehicles)

Vehicle *Make (e.g., Ford), model, year*	**Jointly owned?**	**Market value** *What it would sell for*	**Debt** *Total amount owed on debt* **and to whom owed**	**Net Value** *Market value minus debt owed*
(1)	☐	$	$ to:	$
(2)	☐	$	$ to:	$
(3)	☐	$	$ to:	$

☐ *Check this box if you have attached additional pages.*

C. Other assets, if any:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

5. Respondent's debts

Debts and liabilities of Respondent	**Debts and liabilities** **Amount**
(1) Mortgage	$
(2) Car loan	$
(3) Credit card debt	$
(4) Other *Identify:*	$
(5) Other *Identify:*	$
(6) Other *Identify:*	$
(7) Totals from attached pages, if any ☐ *Check this box if you attached additional pages regarding debts and liabilities.*	$
Total	**$**

6. Respondent's expenditures

Type of expense	**Amount** *Check one* ☐ **monthly** ☐ **annual**
(1) House payment or rent	$
(2) Food	$
(3) Insurance *(health, dental, auto, etc.)*	$
(4) Utilities *(gas, electric, water, internet, etc.)*	$
(5) Phone	$
(6) Child support payments	$
(7) Car payment	$

Continued on next page

(8) Credit card payments	$
(9) Other expense *Identify:*	$
(10) Other expense *Identify:*	$
(11) Other expense *Identify:*	$
(11) Totals from attached pages, if any ☐ *Check this box if you attached additional pages regarding expenses.*	$
Total *Total expenditures*	**$**

7. Oath and signature

I, _____, have read this Application, and I certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information provided in this Application is true and correct.

_____ _____, 20___ _____
Month *Day* *Year* *Applicant's signature**

_____ _____, _____ _____
Mailing address *City* *State* *ZIP code*

(____) _____ _____ _____
Phone number *Email address* *Additional email address, if applicable*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Physician or Mental Health Professional's Report of Examination** Iowa Code § 229.10 Iowa Ct. R. 12.13

1. Date and time of examination: _____ ____, 20___ at ____:____ ☐ a.m. ☐ p.m.
Month *Day* *Year* *Time*

2. Respondent's information:

A. Name: _____
Full name: first, middle, last

B. Address: _____ _____, _____ _____
Street address *City* *State* *ZIP code*

C. Date of birth: _____ _____, _____
Month *Day* *Year*

D. Place of birth: _____

E. Sex: _____

F. Occupation: _____

G. Marital status: _____

H. Number of children: _____. Name(s): _____

_____

I. Nearest relative: _____ _____
Name: first, last *Relationship*

_____ _____, _____ _____
Street address *City* *State* *ZIP code*

3. Is this an examination under Iowa Code section 229.11? ☐ Yes ☐ No

4. Did a qualified mental health professional assist with this exam? ☐ Yes ☐ No

If yes, provide that person's name: _____
Mental health professional's name

_____ _____ _____, _____ _____
Business name *Address* *City* *State* *ZIP code*

Attach the mental health professional's report, if written

Continued on next page

5. In your judgment, is Respondent mentally ill? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts, symptoms, and overt acts

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

6. In your judgment, is Respondent treatable and would likely benefit from treatment? ☐ Yes ☐ No
If yes, state recommendations and basis for recommendations

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

7. In your judgment, is Respondent capable of making responsible decisions with respect to hospitalization or treatment? ☐ Yes ☐ No
If no, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

8. In your judgment, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ Yes ☐ No
If yes, state what recent overt acts by Respondent lead you to this conclusion, including approximate date(s) and other relevant facts

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

9. In your judgment, is Respondent likely to inflict serious emotional injury on those unable to avoid contact with Respondent if allowed to remain at liberty without treatment? ☐ Yes ☐ No
If yes, state what recent overt acts by Respondent lead you to this conclusion, including approximate date(s) and other relevant facts

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

10. In your judgment, is Respondent unable to satisfy needs for nourishment, clothing, essential medical care, or shelter so that it is likely Respondent will suffer physical injury, debilitation, or death? ☐ Yes ☐ No
If yes, state basis for answer

☐ *Check this box if you have attached additional pages.*

11. Does Respondent have a prior history of noncompliance with treatment that has been a significant factor in the need for emergency hospitalization or has resulted in acts causing serious physical injury to Respondent's self or others or an attempt to cause physical injury to Respondent's self or others? ☐ Yes ☐ No
If yes, state basis for answer

☐ *Check this box if you have attached additional pages.*

12. Can Respondent be evaluated on an outpatient basis? ☐ Yes ☐ No
State basis for answer

☐ *Check this box if you have attached additional pages.*

13. Can Respondent, without danger to self or others, be released to the custody of a relative or friend during the course of evaluation? ☐ Yes ☐ No
State basis for answer

☐ *Check this box if you have attached additional pages.*

14. Is full-time hospitalization necessary for evaluation? ☐ Yes ☐ No

15. Does Respondent have a prior history of other physical or mental illness? ☐ Yes ☐ No
If yes, specify

☐ *Check this box if you have attached additional pages.*

Continued on next page

16. Was Respondent medicated at the time of examination? ☐ Yes ☐ No

If yes, provide name(s) of the medication, dosage, approximate date and time administered, and probable effects on Respondent

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

17. Physician or mental health professional's signature

_____ _____

Printed name *Signature**

_____ _____

Title *Name of facility*

_____

Mailing address

_____, _____ _____

City *State* *ZIP code*

(____) _____

Phone number

_____ _____

Email address *Additional email address, if applicable*

_____ _____, 20_____

Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Stipulation is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Stipulation Regarding Respondent's Presence** Iowa Code § 229.12 Iowa Ct. R. 12.19(2)

1. I, _____, am an attorney representing Respondent in this matter
Full name: first, middle, last

and stipulate that Respondent need not be present at the hearing to determine whether Respondent has a serious mental impairment.

2. On, _____ ____, 20___, I conversed with Respondent about the
Month *Day* *Year*

hearing and Respondent's absence from the hearing.

3. In my judgment,

A. ☐ Respondent can make no meaningful contribution to the hearing.

B. ☐ Respondent has waived the right to be present at the hearing.

I base this judgment on the following grounds:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

4. Attorney's signature

_____ /s/_____
Printed name *Signature*

_____
Law firm, if applicable

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____ _____
Phone number *Attorney PIN number*

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20____
Month *Day* *Year*

Rule 12.36—Form 6: ***Notice of Medication***

In the Iowa District Court for _____ County
County where Notice is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Notice of Medication** Iowa Code § 229.12(1)

1. I, _____, physician, inform the court that Respondent was
Physician's name

medicated with the following: *Include the name(s) of the medication (including chemotherapy), dosage, and approximate date and time administered.*

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

2. This medication may cause the following effects on Respondent:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

3. Physician's signature

_____ _____
Printed name *Signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Application is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Application for Extension of Time for Psychiatric Evaluation** Iowa Code § 229.13

1. I,_____, chief medical officer of _____,
Name of chief medical officer *Hospital or facility*
request an extension of time not to exceed seven days in order to complete the psychiatric evaluation of Respondent.

2. I request this extension because:

_____
_____
_____
_____
_____
_____

☐ *Check this box if you have attached additional pages.*

3. It is my opinion that this extension is in Respondent's best interests.

4. Chief medical officer's signature

_____ _____
Printed name *Signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Chief Medical Officer's Report of Psychiatric Evaluation** Iowa Code § 229.14

1. I,_____, chief medical officer of _____,
Name of chief medical officer *Hospital or facility*
and for the Report of Psychiatric Evaluation of Respondent, state the following.

2. Date and time of evaluation: _____ ____, 20___ at ____:____ ☐ a.m. ☐ p.m.
Month *Day* *Year* *Time*

3. State treatment Respondent received during the present evaluation period:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

4. Was Respondent medicated at the time of evaluation? ☐ Yes ☐ No
If yes, provide name(s) of the medication, dosage, approximate date and time administered, and probable effects on Respondent

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

5. Have there been previous psychiatric illnesses? ☐ Yes ☐ No
If yes, complete the following:

A. Approximate date(s) of illness:_____

B. Was hospitalization or treatment necessary? ☐ Yes ☐ No
If yes, provide place, date, length of stay, and condition on discharge

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

6. Does Respondent have any other disease or injury at present? ☐ Yes ☐ No
If yes, specify

☐ *Check this box if you have attached additional pages.*

7. Respondent's past medical history:

☐ *Check this box if you have attached additional pages.*

8. Is Respondent suffering from any transmissible disease within the past three weeks or has Respondent been exposed to such a disease within the past three weeks?
If yes, specify ☐ Yes ☐ No

☐ *Check this box if you have attached additional pages.*

9. Is there a family history of mental illness, mental deficiency, or convulsive disorder? ☐ Yes ☐ No
If yes, give name(s), relationship, and type of disorder

☐ *Check this box if you have attached additional pages.*

10. In your opinion, is Respondent mentally ill? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts, symptoms, and overt acts

☐ *Check this box if you have attached additional pages.*

Continued on next page

11. In your opinion, is Respondent treatable and would likely benefit from treatment? ☐ Yes ☐ No

If yes, state recommendations and basis for recommendations

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

12. In your opinion, is Respondent capable of making responsible decisions with respect to hospitalization or treatment? ☐ Yes ☐ No

If no, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

13. In your opinion, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state what recent overt acts by Respondent lead you to this conclusion, including approximate date(s) and other relevant facts

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

14. In your opinion, is Respondent likely to inflict serious emotional injury on those unable to avoid contact with Respondent if Respondent is allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state what recent overt acts by Respondent lead you to this conclusion, including approximate date(s) and other relevant facts

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

15. In your opinion, is Respondent unable to satisfy needs for nourishment, clothing, essential medical care, or shelter so that it is likely Respondent will suffer physical injury, debilitation, or death? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

16. Does Respondent have a prior history of noncompliance with treatment and the noncompliance has either (1) been a significant factor in the need for emergency hospitalization or (2) has resulted in acts causing serious physical injury to Respondent's self or others or an attempt to cause physical injury to Respondent's self or others? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

17. Proposed treatment and placement

In your opinion,

Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(*a*).

B. ☐ Respondent is seriously mentally impaired and is in need of full-time custody, care, and inpatient treatment in a hospital, and is likely to benefit from treatment. Iowa Code § 229.14(1)(*b*).

Recommended further treatment:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

C. ☐ Respondent is seriously mentally impaired and in need of treatment, but does not require full-time hospitalization. Iowa Code § 229.14(1)(*c*).

Recommended treatment on an outpatient or other appropriate basis:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

D. ☐ Respondent is seriously mentally impaired and in need of full-time custody and care, but is unlikely to benefit from further inpatient treatment in a hospital. Iowa Code § 229.14(1)(*d*).

Recommended alternative placement:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

18. State facts and reasons supporting your recommended treatment and that the treatment is the least restrictive and effective for Respondent:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

19. Chief medical officer's signature

_____ _____
Printed name *Signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ **County**
County where Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Chief Medical Officer's Periodic Report (Respondent Inpatient)** Iowa Code § 229.15(1)

1. I,_____, chief medical officer of _____,
Name of chief medical officer *Hospital or facility*
and for the Periodic Report of Respondent, state the following.

2. An order for continued hospitalization of Respondent at this facility was entered _____ ____, 20____.
Month *Day* *Year*

3. In your opinion, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

4. In your opinion, is Respondent mentally ill? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts and symptoms

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

5. In your opinion, is Respondent capable of making responsible decisions with respect to hospitalization or treatment? ☐ Yes ☐ No
If no, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

6. In your opinion, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

7. In your opinion, is Respondent likely to inflict serious emotional injury on those unable to avoid contact with Respondent if Respondent is allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

8. In your opinion, is Respondent unable to satisfy needs for nourishment, clothing, essential medical care, or shelter so that it is likely Respondent will suffer physical injury, debilitation, or death? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

9. Does Respondent have a prior history of noncompliance with treatment and the noncompliance has either (1) been a significant factor in the need for emergency hospitalization or (2) has resulted in acts causing serious physical injury to Respondent's self or others or an attempt to cause physical injury to Respondent's self or others? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

10. Respondent's placement *Check one*

A. ☐ Respondent was tentatively discharged on _____ ____, 20____,
Month *Day* *Year*

pursuant to Iowa Code section 229.16, because, in your opinion, Respondent no longer requires further treatment or care for serious mental impairment.
Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **10**(A), stop and sign below.*

B. ☐ Respondent continues to be hospitalized in this hospital.

C. ☐ Respondent was transferred to _____
Location

on _____ _____, 20____, pursuant to Iowa Code section
Month *Day* *Year*

229.15(5), because in your opinion it was in the best interests of Respondent.

D. ☐ Respondent was placed on leave on _____ ____, 20____,
Month *Day* *Year*

pursuant to Iowa Code section 229.15(5), because in your opinion it was in the best interests of Respondent.

Respondent was instructed to return on _____ ____, 20____,
Month *Day* *Year*

11. Proposed treatment and placement

In your opinion,
Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(*a*).
Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **11**(A), stop and sign below.*

B. ☐ Respondent is seriously mentally impaired and in need of full-time custody, care, and inpatient treatment in a hospital, and is considered likely to benefit from treatment. Iowa Code § 229.14(1)(*b*).

Continued on next page

(1) Estimated further length of time that Respondent will require treatment in a hospital:
Check one

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommendation:
Check one

a. ☐ Respondent remain in this hospital.

b. ☐ Respondent be transferred to _____.

c. ☐ Respondent be placed or remain on leave until _____ ____, 20____.
Month *Day* *Year*

(3) Recommended further treatment:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

C. ☐ Respondent is seriously mentally impaired and in need of treatment but does not require full-time hospitalization. Iowa Code § 229.14(1)(*c*).

Recommended treatment on an outpatient or other appropriate basis:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

D. ☐ Respondent is seriously mentally impaired and in need of full-time custody and care, but is unlikely to benefit from further inpatient treatment in a hospital. Iowa Code § 229.14(1)(*d*).

Recommended alternative placement:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

12. State facts and reasons supporting your recommended treatment and that the treatment is the least restrictive and effective for Respondent:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

13. Chief medical officer's signature

_____ _____
Printed name *Signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ **County**
County where Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Periodic Report (Respondent Outpatient)** Iowa Code § 229.15(2)

1. I,_____, of _____,
Full name *Hospital or facility*

and for the Periodic Report of Respondent, state the following.

2. An order for treatment of Respondent on an outpatient or other appropriate basis at this facility was entered _____ ____, 20____.
Month *Day* *Year*

3. In your opinion, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

4. In your opinion, is Respondent mentally ill? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts and symptoms

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

5. In your opinion, is Respondent capable of making responsible decisions with respect to hospitalization or treatment? ☐ Yes ☐ No
If no, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

6. In your opinion, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

7. In your opinion, is Respondent likely to inflict serious emotional injury on those unable to avoid contact with Respondent if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

8. In your opinion, is Respondent unable to satisfy needs for nourishment, clothing, essential medical care, or shelter so that it is likely Respondent will suffer physical injury, debilitation, or death? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

9. Does Respondent have a prior history of noncompliance with treatment and the noncompliance has either (1) been a significant factor in the need for emergency hospitalization or (2) has resulted in acts causing serious physical injury to Respondent's self or others or an attempt to cause physical injury to Respondent's self or others? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

10. Respondent's treatment *Check one*

A. ☐ Respondent was tentatively discharged on _____ ____, 20____.
Month *Day* *Year*

Explanation:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **10**(A), stop and sign below*

B. ☐ Respondent is in treatment in accordance with the court's order.

C. ☐ Respondent is failing or refusing to submit to treatment as the court ordered and, in your opinion, has not shown good cause.

11. Proposed treatment and placement

In your opinion,
Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(*a*).
Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **11**(A), stop and sign below.*

B. ☐ Respondent is seriously mentally impaired and in need of full-time custody, care, and inpatient treatment in a hospital and is considered likely to benefit from treatment. Iowa Code § 229.14(1)(*b*).

Recommended inpatient treatment:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

C. ☐ Respondent is seriously mentally impaired and in need of treatment but does not require full-time hospitalization and can continue on an outpatient or other appropriate basis. Iowa Code § 229.14(1)(*c*).

(1) Estimated further length of time that Respondent will require outpatient or other appropriate treatment at this facility:
Check one

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommended further treatment on an outpatient or other appropriate basis:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

D. ☐ Respondent is seriously mentally impaired and in need of full-time custody and care but is unlikely to benefit from inpatient treatment in a hospital. Iowa Code § 229.14(1)(*d*).

Recommended alternative placement:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

12. State facts and reasons supporting your recommended treatment and that the treatment is the least restrictive and effective for Respondent:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

13. Signature

_____ _____
*Signature** *Printed name*

_____ _____
*Title*** *Name of facility*

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

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***The **medical director** of the facility or the **psychiatrist** or **psychiatric advanced registered nurse practitioner** treating Respondent may complete this Periodic Report. Iowa Code § 229.15(3)*(a).

*An **advanced registered nurse practitioner** who is not certified as a psychiatric advanced registered nurse practitioner but who meets the qualifications set forth in the definition of a mental health professional in Iowa Code section 228.1 may complete this Periodic Report. Iowa Code § 229.15(3)*(b).

In the Iowa District Court for _____ County
County where Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Periodic Report (Alternative Facility Placement)** Iowa Code § 229.15(4)

1. I,_____, chief medical officer of _____,
Name of chief medical officer *Hospital or facility*
and for the Periodic Report of Respondent, state the following.

2. An order for continued placement of Respondent at this facility was entered
_____ ____, 20____.
Month *Day* *Year*

3. In your opinion, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

4. In your opinion, is Respondent mentally ill? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts and symptoms

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

5. In your opinion, is Respondent capable of making responsible decisions with respect to hospitalization or treatment? ☐ Yes ☐ No
If no, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

6. In your opinion, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

7. In your opinion, is Respondent likely to inflict serious emotional injury on those unable to avoid contact with Respondent if allowed to remain at liberty without treatment? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

8. In your opinion, is Respondent unable to satisfy needs for nourishment, clothing, essential medical care, or shelter so that it is likely Respondent will suffer physical injury, debilitation, or death? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

9. Does Respondent have a prior history of noncompliance with treatment and the noncompliance has either (1) been a significant factor in the need for emergency hospitalization or (2) has resulted in acts causing serious physical injury to Respondent's self or others or an attempt to cause physical injury to Respondent's self or others? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

10. Respondent's placement *Check one*

A. ☐ Respondent was tentatively discharged on _____ ____, 20____.
Month *Day* *Year*

Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **10**(A), stop and sign below.*

B. ☐ Respondent continues to be placed at this facility.

11. Proposed treatment and placement

In my opinion,
Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(*a*).
Explanation

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

STOP *If you checked **11**(A), stop and sign below.*

B. ☐ Respondent is seriously mentally impaired and in need of full-time custody, care, and inpatient treatment in a hospital, and is considered likely to benefit from treatment. Iowa Code § 229.14(1)(*b*).

Recommended inpatient treatment:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

C. ☐ Respondent is seriously mentally impaired and in need of treatment but does not require full-time hospitalization. Iowa Code § 229.14(1)(*c*).

Recommended treatment on an outpatient or other appropriate basis:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

Continued on next page

D. ☐ Respondent is seriously mentally impaired and in need of full-time custody and care, but is unlikely to benefit from further inpatient treatment in a hospital. Iowa Code § 229.14(1)(*d*).

(1) Estimated further length of time Respondent will require treatment in this facility:
Check one

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommendation:
Check one

a. ☐ Respondent remain in this facility.

b. ☐ Respondent be transferred to _____.

(3) Recommended further treatment:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

12. State facts and reasons supporting your recommended treatment and that the treatment is the least restrictive and effective for Respondent:

_____

_____

_____

☐ *Check this box if you have attached additional pages.*

13. Signature

_____ _____
*Signature** *Printed name*

_____ _____
Title *Name of facility*

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20_____
Month *Day* *Year*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

Rule 12.36—Form 12: ***Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee***

In the Iowa District Court for _____ County
County where Notice is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee** Iowa Code § 229.21(3)

1. To: The clerk of the district court for _____ County.
County where Notice is filed

2. Respondent appeals to the district court the findings of the magistrate or judicial hospitalization referee that Respondent is seriously mentally impaired, made on

_____ ____, 20____.
Month *Day* *Year*

3. Respondent requests a review of this matter by a judge of the district court in accordance with Iowa Code section 229.21(3).

4. Signature

_____ _____
Printed name *Signature**

Date: _____ ____, 20____.
Month *Day* *Year*

Signed by:
Check one

☐ Respondent

☐ Attorney

☐ Next friend of Respondent

☐ Guardian of Respondent

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Motion is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Attorney's Motion to Withdraw** Iowa Code § 229.19(1)(*c*)

1. The court appointed the undersigned attorney to represent Respondent in this matter.
2. After hearing on the matter, the court found Respondent was seriously mentally impaired.
3. In my opinion there is no further need of legal services at this time.
4. Pursuant to Iowa Code section 229.19(1)(*c*), I request that the court appoint a Mental Health Advocate for Respondent, if one has not been appointed already, and that I be relieved from further representation of Respondent in this matter and be allowed to withdraw.
5. **Attorney's signature**

_____ /s/_____
Printed name *Signature*

_____
Law firm, if applicable

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____ _____
Phone number *Attorney PIN number*

_____ _____
Email address *Additional email address, if applicable*

_____ _____, 20____
Month *Day* *Year*

Rule 12.36—Form 14a: ***Claim for Attorney Fees***

In the Iowa District Court for _____ County
County where Claim is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Claim for Attorney Fees** Iowa Code § 229.8

1. I, the undersigned attorney, state that the court appointed me to represent Respondent, alleged to be seriously mentally impaired, pursuant to Iowa Code section 229.8, and that I have completed representation of Respondent in this matter as set forth in the itemized statement provided with this Claim and that I have not directly or indirectly received or entered into a contract to receive any compensation for such services from any sources.

2. I request an order to be compensated in accordance with the provisions of Iowa Code section 229.8.

3. Oath and signature

I, _____, have read this Claim, and certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information provided in this Claim is true and correct.

_____ _____, 20___ /s/_____
Month *Day* *Year* *Claimant's signature*

_____ _____, _____ _____
Mailing address *City* *State* *ZIP code*

(___) _____ _____
Phone number *Email address*

_____ _____
Additional email address, if applicable *Attorney PIN number*

In the Iowa District Court for _____ County
County where Claim is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Claim for Physician Fees** Iowa Code § 229.10

1. I, the undersigned physician, state that pursuant to Iowa Code section 229.10, I examined Respondent, alleged to be seriously mentally impaired, and that services have been completed as set forth in the itemized statement provided with this Claim and that I have not directly or indirectly received or entered into a contract to receive any compensation for such services from any sources.

2. I request an order to be compensated in accordance with the provisions of Iowa Code section 229.10.

3. Oath and signature

I, _____, have read this Claim, and certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information provided in this Claim is true and correct.

_____ _____, 20___ _____
Month *Day* *Year* *Claimant's signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*

In the Iowa District Court for _____ County
County where Notice is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Notice of Appointment of Mental Health Advocate** Iowa Code § 229.19(1)(*c*)

To: _____,
Name of Respondent

You are notified that _____ has been appointed
Name of Mental Health Advocate

your Mental Health Advocate. Your Advocate will be communicating with you and representing your interests in this proceeding relating to your hospitalization and treatment.

Signature

_____ _____, 20___ /s/_____
Month *Day* *Year* *Clerk's signature*