

Rule 12.36—Form 1: Application Alleging Serious Mental Impairment

	In the Iowa District Court for	County where Application is filed			
In t	the Matter of	No			
Re	spondent Full name: first, middle, last	Application Alleging Serious Mental Impairment			
	eged to be Seriously Mentally paired	Iowa Code § 229.6			
1.	I, Full name: first, middle, last serious mental impairment.	, allege Respondent is suffering from			
2.	In support of this Application, I state:				
•	Check this box if you have attached additional po				
3.	lacks judgmental capacity due to seriou	spondent is a danger to self or others and us mental impairment. ☐ Yes ☐ No			
4.	I request that: Check one				
	A. Respondent be taken into immediate custody.				
	B. Respondent not be taken into imme	ediate custody.			
5.	In support of this Application, I have att Check all that apply	ached:			
	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.				
	designee. NOTE: This option is only ava	and reduced to writing by the clerk or the clerk's ailable when circumstances make it infeasible to obtain, or supplement, the information under either subparagraph			

Continued on next page

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Attorney Help Check one

Name of	Name of attorney or organization, if any		Attorney's PIN – Ask the attorney		
Business	s address of attorney or organization	City	State	ZIP code	
() Attorney	's phone number	Attorney's emo	ail address – optiona	ıl	
l,	l name: first, middle, last	,	pplication, and	•	
I,	, have and pursuant to the law this Application is true and co	s of the State		•	
I,	, hav I name: first, middle, last erjury and pursuant to the law	s of the State		•	

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https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.

In ti	he Iowa Dis	trict Court fo	County where A	Affidavit is filed		unty	
In the Matter of	of		No				
Respondent F	ull name: first, mi	ddle, last		Affidavit in Support of Application Alleging Serious Mental Impairment			
Alleged to be Impaired	Seriously N	lentally					
						Iowa Code § 229.6	
Full name: first, 1		, state tha	t I am acquair	nted with R	esponder	t who resides at	
Street address		City		County	State	ZIP code	
Check this box if		ied additional pa	ges.				
Oath and sign	ature						
l,	ma: first_middle	last	, have read tl	nis Affidavi	it, and I c	ertify under	
penalty of perjuthis Affidavit is	iry and purs	uant to the la	ws of the Sta	te of Iowa	that the i	nformation in	
		, 20					
Month	Day	Year Affia	int's signature*				
Mailing address			City		,	ZIP code	
()							
Phone number		Email address		Additiona	ıl email addı	ess, if applicable	
*This form may be s the-public/court-for				structions at <u>h</u>	ttps://www.i	owacourts.gov/for-	

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Rule 12.36—Form 3: Application for Appointment of Counsel and Financial Statement

		In the Iowa District Court for $\frac{1}{C}$	ounty where Application is filed	County
In	the	Matter of	No	
Re	Respondent Full name: first, middle, last		Application for Counsel and Fin	Appointment of ancial Statement
	lege paiı	ed to be Seriously Mentally red		
1.	Ι, _			, state that I am:
	Ì	Print your full name: first, middle, last		
	Ch	eck one		
		Respondent		
		Respondent's spouse		
		Next friend of Respondent		
		Guardian of Respondent		
		equest the court appoint counsel to recause Respondent is financially unab	•	t public expense
2.	Re	espondent's information		
	A.	Respondent's full name: first, middle, last		
		Kesponaent s juii name: jirst, miaaie, iast		
		Street address	City	State ZIP code
		Marital status	Number of dependents	
	В.	Respondent's age:		
	C.	Is Respondent currently in custody?]Yes □No	
	D.	Respondent's employment status:		
		☐ Full-time		
		☐ Part-time (approximate hours per w	eek:)	
		☐ Unemployed		
		,		

Continued on next page

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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

	In	come
Average current income for Respondent	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 <i>Identify:</i>		\$
(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		\$

В.	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

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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

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5. Respondent's debts

Debts and liabilities of Respondent	Debts and liabilities
Booto and nasminos of Respondent	Amount
(1) Mortgage	\$
(2) Car loan	\$
(3) Credit card debt	\$
(4) Other Identify:	\$
(5) Other Identify:	\$
(6) Other <i>Identify:</i>	\$
(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

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7.

(8) Credit card payme	nts			\$	
(9) Other expense Identify:				\$	
(10) Other expense <i>Identify:</i>				\$	
(11) Other expense <i>Identify:</i>				\$	
(11) Totals from attach Check this box if you atta		egarding expenso	es.	\$	
Total Total expenditures				\$	
Oath and signature					
l,		have read th	nis Applicat	ion, ar	nd I certify under
penalty of perjury and provided in this Applica	pursuant to the lation is true and	correct.	State of Iow	a that	the information
Month Day	, 20	's signature*			
Mailing address		City		State	ZIP code
() Phone number	Email address		Additional er	nail add	ress, if applicable

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^{*}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 4: Physician or Mental Health Professional's Report of Examination

	In the lowa District Court for _	County
		County where Report is filed
In	the Matter of	No
	espondent Full name: first, middle, last	Physician or Mental Health Professional's Report of Examination
	paired	Iowa Code § 229.10 Iowa Ct. R. 12.13
1.	Date and time of examination:	$\underline{\hspace{1cm}}_{Day}$, 20 at $\underline{\hspace{1cm}}_{Time}$: $\underline{\hspace{1cm}}$ a.m.
2.	Respondent's information:	
	A. Name:	
	Full name: first, middle, last	
	B. Address:	City , State ZIP code
	C. Date of birth:	Year -
	D. Place of birth:	
	E. Sex:	
	F. Occupation:	
	G. Marital status:	
	H. Number of children: Name(s	3):
	I. Nearest relative: Name: first, last	Relationship
	Street address	City , State ZIP code
3.	Is this an examination under Iowa Code	2
4.	Did a qualified mental health profession	
╼.		nai assist with this exam:
	If yes, provide that person's name:	al health professional's name
	Business name Address	City , State ZIP code
	Attach the mental health professional's report, if w	ritten

Continued on next page

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In your judgment, is Respondent mentally ill? If yes, state diagnosis including supporting facts, symptoms, and overt acts	□Yes	□N
Check this box if you have attached additional pages.		
In your judgment, is Respondent treatable and would likely benefit from treatment? If yes, state recommendations and basis for recommendations	□Yes	□N
Check this box if you have attached additional pages.		
In your judgment, is Respondent capable of making responsible decrespect to hospitalization or treatment? If no, state basis for answer	cisions wi □ Yes	th □ N
Check this box if you have attached additional pages.		
In your judgment, is Respondent likely to physically injure self or othe to remain at liberty without treatment? If yes, state what recent overt acts by Respondent lead you to this conclusion, including a and other relevant facts	□Yes	\square N
Check this box if you have attached additional pages.		
In your judgment, is Respondent likely to inflict serious emotional in unable to avoid contact with Respondent if allowed to remain at liber treatment? If yes, state what recent overt acts by Respondent lead you to this conclusion, including a and other relevant facts	erty withou ☐ Yes	ut □N
Check this box if you have attached additional pages.		

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10.	In your judgment, is Respondent unable to satisfy needs for nourishmessential medical care, or shelter so that it is likely Respondent will sinjury, debilitation, or death?		'sical
	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 treatmed been a significant factor in the need for emergency hospitalization or acts causing serious physical injury to Respondent's self or others or cause physical injury to Respondent's self or others? If yes, state basis for answer	has resu	ulted in npt to
12.	☐ Check this box if you have attached additional pages. Can Respondent be evaluated on an outpatient basis? State basis for answer	□Yes	□No
	Check this box if you have attached additional pages.		
13.	Can Respondent, without danger to self or others, be released to the relative or friend during the course of evaluation? State basis for answer	custody ☐ Yes	of a ☐ No
	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? If yes, specify	□Yes	□No
	Check this box if you have attached additional pages.		
	Continued on next page		

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Was Respondent medicated at the time of examination? ☐ Yes ☐ N 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	l additional pa	ges.	
Physician or n	nental health	professio	nal's signature	
Printed name			Signature*	
Title			Name of facility	
Mailing address				
City			State	ZIP code
() Phone number				
Email address			Additional emai	l address, if applicable
		_, 20	_	
Month	Day	Year		

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^{*}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 5: Stipulation Regarding Respondent's Presence

	In the lowa District Court for $\frac{1}{C}$	County where Stipulation	cis filed County		
In ¹	the Matter of				
Re	spondent Full name: first, middle, last	Stipulation	Regarding Respondent's Presence		
	eged to be Seriously Mentally paired		Iowa Code § 229.12 Iowa Ct. R. 12.19(2)		
1.	I,, am an a	attorney represen	ting Respondent in this matter		
	and stipulate that Respondent need not whether Respondent has a serious mer	•	ne hearing to determine		
2.	On, $\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$	conversed with F	Respondent about the		
	hearing and Respondent's absence from	m 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 gr	ounds:			
	Check this box if you have attached additional pe	ages.			
4.	Attorney's signature				
		/s/			
	Printed name	Signature			
	Law firm, if applicable				
	Mailing address				
	City	State	ZIP code		
	()				
	Phone number	Attorney PIN nu	umber		
	Email address	Additional emai	l address, if applicable		
	Month Day Yea				
	monin Duy Teu	, i			

	In the Iowa District Court f	County where Notice is fa	County
t	he Matter of		
es	spondent Full name: first, middle, last	' Noti	ce of Medication
	eged to be Seriously Mentally paired		Iowa Code § 229.12(1
•	I,	e the name(s) of the medica	
	Check this box if you have attached addition	anal nages	
•	This medication may cause the foll	1 0	spondent:
		owing effects on Res	spondent:
	This medication may cause the foll Check this box if you have attached addition	owing effects on Res	spondent:
	This medication may cause the foll Check this box if you have attached addition Physician's signature	owing effects on Res	spondent:
	This medication may cause the foll Check this box if you have attached addition Physician's signature Printed name	owing effects on Res	spondent:
	This medication may cause the foll Check this box if you have attached addition Physician's signature Printed name Name of hospital or facility	owing effects on Res	zIP code
	This medication may cause the foll Check this box if you have attached addition Physician's signature Printed name Name of hospital or facility Mailing address City ()	owing effects on Resonal pages. Signature*	

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Rule 12.36—Form 7: Application for Extension of Time for Psychiatric Evaluation

	ourt for	where Application	n is filed	
the Matter of				
espondent Full name: first, middle, last		Application for Extension of Time for		
		Psychiatric Evaluation		
leged to be Seriously Mentally paired	'		Iowa Code § 229.	
I,, ch Name of chief medical officer	ief medical of	fficer of	ital or facility	
request an extension of time new psychiatric evaluation of Resp		seven days	in order to complete the	
I request this extension becau	se:			
☐ Check this box if you have attached a	additional pages.			
☐ Check this box if you have attached of It is my opinion that this extensi	• •	pondent's b	est interests.	
It is my opinion that this extens	sion is in Res	pondent's b	est interests.	
	sion is in Res	pondent's b	est interests.	
It is my opinion that this extens	sion is in Res	spondent's be	est interests.	
It is my opinion that this extens	sion is in Res		est interests.	
It is my opinion that this extension. Chief medical officer's signature. Printed name	sion is in Res		est interests.	
It is my opinion that this extension Chief medical officer's signature Printed name Name of hospital or facility	sion is in Res		est interests.	
It is my opinion that this extension Chief medical officer's signate Printed name Name of hospital or facility Mailing address	sion is in Res	Signature*		
It is my opinion that this extension Chief medical officer's signate Printed name Name of hospital or facility Mailing address	sion is in Res	Signature*		
It is my opinion that this extense Chief medical officer's signate Printed name Name of hospital or facility Mailing address City ()	sion is in Res	Signature* State		
It is my opinion that this extense Chief medical officer's signal Printed name Name of hospital or facility Mailing address City (sion is in Res	Signature* State	ZIP code	

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Rule 12.36—Form 8: Chief Medical Officer's Report of Psychiatric Evaluation

	In the lowa District Court for _	County where Report is filed		
In	the Matter of	No		
Re	spondent Full name: first, middle, last	Chief Medical Officer's Report of Psychiatric Evaluation		
	eged to be Seriously Mentally paired	Iowa Code § 229.14		
1.	I,, chief medic			
	and for the Report of Psychiatric Evalua	ation of Respondent, state the following.		
2.	Date and time of evaluation: Month	Day , 20 at $Time$: \square a.m. \square p.m.		
3.	State treatment Respondent received d	luring the present evaluation period:		
	☐ Check this box if you have attached additional po	ages.		
4.	Was Respondent medicated at the time			
	Check this box if you have attached additional po	ages.		
5.	Have there been previous psychiatric ill <i>If yes, complete the following:</i>	nesses?		
	A. Approximate date(s) of illness:			
	B. Was hospitalization or treatment neces If yes, provide place, date, length of stay, and contains the stay of th			
	Check this box if you have attached addition	val pages.		

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9.	Is there a family history of mental illness, mental deficiency, or convudisorder? If yes, give name(s), relationship, and type of disorder	llsive □Yes	□No
	Check this box if you have attached additional pages.		
10.	In your opinion, is Respondent mentally ill? If yes, state diagnosis including supporting facts, symptoms, and overt acts	□Yes	□No
	Check this box if you have attached additional pages.		

Check this box if you have attached additional pages.

Continued on next page

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

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15.	esseninjury,	r opinion, is Respondent unable to satisfy needs for nourishment, clothing, tial medical care, or shelter so that it is likely Respondent will suffer physical debilitation, or death? — Yes — No ate basis for answer
		Labia han if ann hann agus had a diidian al ann an
16	_	k this box if you have attached additional pages.
10.	nonco hospita Respo self or	Respondent have a prior history of noncompliance with treatment and the mpliance has either (1) been a significant factor in the need for emergency alization or (2) has resulted in acts causing serious physical injury to indent's self or others or an attempt to cause physical injury to Respondent's others?
4-	_	k this box if you have attached additional pages.
17.	-	esed treatment and placement
	In you Check o	r opinion, ne
	A. 🗆	Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(a).
	В. 🗌	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 \S 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 \S 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

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180	160	
ET.	. "	à.
197 4	200	S)
髓质	35	23
80-		7

D. 🗌	•	ikely to be	•	•	ed of full-time custody and reatment in a hospital. lowa
	Recommended	d alternativ	ve placeme	nt:	
	Check this box	if you have	attached addi	tional pages.	
			• •	recommended ective for Respo	treatment and that the indent:
-					
Che	ck this box if you ha	ve attached	additional pa	ges.	
	ck this box if you ha		•	ges.	
	medical office		•	ges. Signature*	
9. Chief Printed	medical office	er's signa	•		
9. Chief Printed Name of	medical office	er's signa	•		
9. Chief Printed Name of	medical office	er's signa	•		ZIP code
Printed Name of	medical office	er's signa	•	Signature*	ZIP code
Printed Name of	medical office name f hospital or facility address	er's signa	•	Signature*	ZIP code
Printed Name of Mailing City	medical office name f hospital or facility address umber	er's signa	•	Signature* Signature State	ZIP code il address, if applicable
Printed Name of Mailing City Phone in	medical office name f hospital or facility address umber	er's signa	•	Signature* Signature State	

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Rule 12.36—Form 9: Chief Medical Officer's Periodic Report (Respondent Inpatient)

	In the Iowa District Court for _	County where Report is filed	County		
In t	the Matter of	No.			
	spondent Full name: first, middle, last eged to be Seriously Mentally	Chief Medica Periodic I (Respondent	Report	t	
lm	paired		Iowa Code §	229.15(1)	
1.	I,, chief medic	al officer of	 ility	<u>.</u>	
	and for the Periodic Report of Respond				
2.	An order for continued hospitalization of entered	f Respondent at this fac			
3.	In your opinion, Respondent's condition				
٥.	A. ☐ Has improved.				
	B. Remains unchanged.				
	C. Has deteriorated.				
	Explanation				
	-				
	Check this box if you have attached additional pe	ages.			
4.	In your opinion, is Respondent mentally If yes, state diagnosis including supporting facts and		□Yes	□No	
	Check this box if you have attached additional pe	ages.			
5.	In your opinion, is Respondent capable respect to hospitalization or treatment? If no, state basis for answer	of making responsible	decisions with Yes	□No	
		ages.			
	Continued	on next page			

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1	In your opinion, is Respondent likely to physically injure self or others to remain at liberty without treatment? If yes, state basis for answer	if allowed ☐ Yes ☐ No
•		
	Check this box if you have attached additional pages.	
	In your opinion, is Respondent likely to inflict serious emotional injury unable to avoid contact with Respondent if Respondent is allowed to liberty without treatment? If yes, state basis for answer	
-	Check this box if you have attached additional pages.	
i	In your opinion, is Respondent unable to satisfy needs for nourishmer essential medical care, or shelter so that it is likely Respondent will suinjury, debilitation, or death? If yes, state basis for answer	
•		
	Check this box if you have attached additional pages.	
	Does Respondent have a prior history of noncompliance with treatme noncompliance has either (1) been a significant factor in the need for hospitalization or (2) has resulted in acts causing serious physical injurks Respondent's self or others or an attempt to cause physical injury to self or others? If yes, state basis for answer	emergency ury to
٠		
•		
[Check this box if you have attached additional pages.	

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10.	R	espo	ondent's placement Check one
	Α	. 🗆	Respondent was tentatively discharged on $\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
			pursuant to Iowa Code section 229.16, because, in your opinion, Respondent no longer requires further treatment or care for serious mental impairment. <i>Explanation</i>
			Check this box if you have attached additional pages.
	ST	lf y	you checked $10(A)$, stop and sign below.
	В	. 🗆	Respondent continues to be hospitalized in this hospital.
	С	. 🗆	Respondent was transferred to
			on , 20 , pursuant to Iowa Code section
			on
			229.15(5), because in your opinion it was in the best interests of Respondent.
	D	. 🗆	Respondent was placed on leave on $\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
			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 $\underline{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
11.	P	ropo	sed treatment and placement
		•	r opinion,
		heck o —	
	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.
	SI	OF If y	ou checked $11(A)$, stop and sign below.
	В	. 🗆	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 \S 229.14(1)(b).

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		(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
		(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 $\S 229.14(1)(c)$.
			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)(<i>d</i>).
			Recommended alternative placement:
			Check this box if you have attached additional pages.
12.			facts and reasons supporting your recommended treatment and that the ent is the least restrictive and effective for Respondent:
		Chec	k this box if you have attached additional pages.
			Continued on next page

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13. Chief medical officer's signature

Printed name	Signature*	
Name of hospital or facility		
Mailing address		
City	State	ZIP code
()		
Email address	Additional emai	il address, if applicable
$\underbrace{\hspace{1cm}}_{\textit{Month}}, \underbrace{\hspace{1cm}}_{\textit{Day}}, \underbrace{\hspace{1cm}}_{\textit{Year}}$	_	

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^{*}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 10: Periodic Report (Respondent Outpatient)

	In the Iowa District Court for _	County where Report is filed	County						
In	the Matter of	No							
Re	spondent Full name: first, middle, last		c Report t Outpatient)						
	eged to be Seriously Mentally paired		Iowa Code §	229.15(2)					
1.	I,, of								
	and for the Periodic Report of Respond	dent, state the following	J.						
2.	An order for treatment of Respondent of this facility was entered	on an outpatient or other	er appropriate ba	asis at					
2	In your opinion, Respondent's condition								
3.	, , ,	II .							
	A. Has improved. B. Begins unabanged								
	_	B. Remains unchanged.							
	C. Has deteriorated. Explanation								
	Check this box if you have attached additional p	ages.							
4.	In your opinion, is Respondent mentall If yes, state diagnosis including supporting facts and		□Yes	□No					
	Check this box if you have attached additional p	pages.							
5.	In your opinion, is Respondent capable respect to hospitalization or treatment? If no, state basis for answer		e decisions with Yes	□No					
	Check this box if you have attached additional p	pages.							
	Continued	on next nage							

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 Rule 12.36—Form 10
 Page 1 of 5

	Rule 12.36—Form 10: Periodic Report (Respondent Outpatient), continued
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?
8.	☐ Check this box if you have attached additional pages. 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?

☐ Check this box if you have attached additional pages.

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10.	Re	spo	ondent's treatment Check one
	A.		Respondent was tentatively discharged on
			Month Day Year Explanation:
			Explanation.
			Check this box if you have attached additional pages.
	5TOP	If yo	ou checked 10 (A), stop and sign below
	В.		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.	Pr	оро	sed treatment and placement
	In y	you	r opinion,
		eck o	
	A.		Respondent does not, as of the date of this Report, require further treatment for serious mental impairment. Iowa Code § 229.14(1)(<i>a</i>). <i>Explanation</i>
	_		Check this box if you have attached additional pages.
	STO	I f y	ou 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 $\S 229.14(1)(b)$.
			Recommended inpatient treatment:
			Check this box if you have attached additional pages.

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	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 \S 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 \S 229.14(1)(d).
			Recommended alternative placement:
			Check this box if you have attached additional pages.
12.			facts and reasons supporting your recommended treatment and that the ent is the least restrictive and effective for Respondent:
		Chec	k this box if you have attached additional pages.

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13. Signature

Signature*	Printed name			
Title**	Name of facility	Name of facility		
Mailing address				
City	, _{State}	ZIP code		
()Phone number				
Email address	Additional ema	il address, if applicable		
$\frac{1}{Month}$, 20	0 Year			

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).

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^{*}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.

^{**}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).



Rule 12.36—Form 11: Periodic Report (Alternative Facility Placement)

	In the lowa District Court for ${Co}$	unty where Report is filed	unty		
In ·	the Matter of	No			
Re	spondent Full name: first, middle, last	Periodic Report (Alterna Placement)			
	eged to be Seriously Mentally paired	,	Jawa Cada S	220 15(4)	
_			Iowa Code §	229.13(4)	
1.	I,, chief medical officer	Hospital or facility		;	
	and for the Periodic Report of Responde	ent, state the following.			
2.	An order for continued placement of Re	spondent at this facility was e	entered		
	$\frac{1}{Month}$, 20 $\frac{1}{Day}$, 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 pa	iges.			
4.	In your opinion, is Respondent mentally If yes, state diagnosis including supporting facts and		□Yes	□No	
	Check this box if you have attached additional po	ages.			
5.	In your opinion, is Respondent capable respect to hospitalization or treatment? If no, state basis for answer	of making responsible decisi	ons with ☐ Yes	□No	
	Check this box if you have attached additional po	ages.			
	Continued (on next page			

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 Rule 12.36—Form 11
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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?					
	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?					
	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?					
	Check this box if you have attached additional pages.					

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10.	Respo	ondent's placement Check one						
	A. 🗌	Respondent was tentatively discharged on						
		Explanation Day Tear						
	_	Check this box if you have attached additional pages.						
	STOP If y	you checked $10(A)$, stop and sign below.						
	В. 🗌	Respondent continues to be placed at this facility.						
11.	Propo	sed treatment and placement						
	In my Check o	opinion,						
	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.						
	sion If	you checked $11(A)$, stop and sign below.						
	В. 🗌	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 \S 229.14(1)(c).						
		Recommended treatment on an outpatient or other appropriate basis:						
		Check this box if you have attached additional pages.						

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1	No of	X.
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le.	200	3
Æ.	-	43

D. 🗌		Ily impaired and in need of full-time custody and com further inpatient treatment in a hospital. Iowa		
(1)	Estimated further length of time Check one	Respondent will req	uire treatment in this facility:	
	a. 🗌 ls			
	b. Cannot be determined a	at this time.		
(2)	Recommendation: Check one			
	a. Respondent remain in the	his facility.		
	b. Respondent be transfer	red to		
(3)	Recommended further treatmen	nt:		
	Check this box if you have attached facts and reasons supporting yent is the least restrictive and	our recommended		
treatm	facts and reasons supporting yent is the least restrictive and	our recommended effective for Respo		
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Chec. Signa Signatur	facts and reasons supporting yent is the least restrictive and least restr	our recommended effective for Respo	ndent:	
Title Mailing City ()	facts and reasons supporting yent is the least restrictive and which the least restrictive and least restrictive a	our recommended effective for Respo	ndent:	
Check Signa Signatur Title Mailing	facts and reasons supporting yent is the least restrictive and which the least restrictive and least restrictive a	our recommended effective for Respo	ndent:	
Title Mailing City ()	facts and reasons supporting yent is the least restrictive and which is the least restrictive and the least restrictive and the least restrictive and which is the least restrictive and the least restrictive and the least restrictive and which is the least restrictive and the least restrictive and which is the least restrictive an	our recommended effective for Respo	ndent:	

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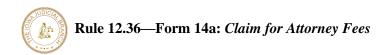
Rule 12.36—Form 12: Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee

	In the lowa District Court for $\frac{1}{C}$	ounty where Notice is filed
In	the Matter of	No
All	spondent Full name: first, middle, last eged to be Seriously Mentally	Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee
lm	paired	Iowa Code § 229.21(3)
1.	To: The clerk of the district court for	
2.	hospitalization referee that Responden	rt the findings of the magistrate or judicial t is seriously mentally impaired, made on
	${Day}$,	<u> </u>
3.	Respondent requests a review of this naccordance with Iowa Code section 22	
4.	Signature	
	Printed name	Signature*
	Date:	20 <i>Year</i>
	Signed by: Check one	
	□ Respondent	
	☐ Attorney	
	□ Next friend of Respondent	
	☐ Guardian of Respondent	
	*This form may be signed either by using a digitized https://www.iowacourts.gov/for-the-public/court-fo	

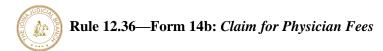
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	In the Iowa District Court for	county where Motion is filed		
In	the Matter of	No		
Re	spondent Full name: first, middle, last	Attorney'	s Motion to Withdraw	
	eged to be Seriously Mentally paired		Iowa Code § 229.19(1)(c)	
1.	The court appointed the undersigned a matter.	ttorney to repres	ent Respondent in this	
2.	After hearing on the matter, the court for impaired.	ound Responden	t was seriously mentally	
3.	In my opinion there is no further need of	of legal services	at this time.	
4.	Pursuant to Iowa Code section 229.19(Mental Health Advocate for Responder and that I be relieved from further repre- be allowed to withdraw.	nt, if one has not	been appointed already,	
5.	Attorney's signature			
		/s/		
	Printed name	Signature		
	Law firm, if applicable			
	Mailing address			
	City	State	ZIP code	
	() Phone number	Attorney PIN nu	umber	
	Email address	Additional emai	l address, if applicable	
	${Month}$, 20 ${Day}$, Yea	ar		

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	In the lowa District Court for $\frac{1}{C}$	County where Claim is filed		
In t	the Matter of	No		
Re	spondent Full name: first, middle, last	Claim for A	Attorne	y Fees
	eged to be Seriously Mentally paired			Iowa Code § 229.8
1.	I, the undersigned attorney, state that the Respondent, alleged to be seriously me section 229.8, and that I have complete matter as set forth in the itemized states have not directly or indirectly received compensation for such services from an	entally impaired, purse of representation of R ment provided with th or entered into a conti	uant to espond is Clain	lowa Code dent in this n and that I
2.	I request an order to be compensated in Code section 229.8.	n accordance with the	provis	ions of Iowa
3.	Oath and signature			
	I,	aws of the State of lov		
	·			
	$\frac{1}{Month} \frac{1}{Day}, \frac{20}{Year} \frac{/s}{Claima}$	nt's signature		
	Mailing address	City	State	ZIP code
	Phone number	Email address		
	Additional email address, if applicable	Attorney PIN number		



	In the	Iowa Distr	ict Cour	t for	unty where Claim is	County
n t	he Matter of				No	
\e	espondent Full name: first, middle, last				Claim for Physician Fees	
	eged to be Se paired	riously Me	ntally			Iowa Code § 229.10
•	examined Re have been co and that I hav	spondent, a empleted as ve not direct	alleged to set forth tly or indi	be ser in the incentification	iously mentall itemized state	va Code section 229.10, I y impaired, and that services ment provided with this Claim ered into a contract to sources.
·-	I request an o		compens	ated in	accordance w	rith the provisions of Iowa
.	Oath and signature					
•	- a aa	jiiatai o				
	_		ldle. last		_, have read t	his Claim, and certify under
′•	I, Print your full to penalty of pen provided in the	name: first, mid rjury and pu nis Claim is	irsuant to true and	the lav	ws of the State	his Claim, and certify under e of lowa that the information
·•	I, Print your full to penalty of pen provided in the	name: first, mid rjury and pu nis Claim is	irsuant to true and	the lav	ws of the State	e of lowa that the information
' .	I, Print your full to penalty of pen provided in the	name: first, mid rjury and pu nis Claim is	irsuant to true and	the lav	ws of the State	e of lowa that the information
' 2	I, Print your full to penalty of pen provided in the	name: first, mid rjury and pu nis Claim is 	irsuant to true and	the lav	ws of the State	e of lowa that the information
′*	I,	name: first, mid rjury and pu nis Claim is 	irsuant to true and	the lav	ws of the State	e of lowa that the information
'	I,	name: first, mid rjury and pu nis Claim is 	irsuant to true and	the lav	ws of the State	e of lowa that the information
'-	I,	name: first, mid rjury and pu nis Claim is 	irsuant to true and	the lav	ws of the State . signature*	e of lowa that the information
'-	I,	name: first, mid rjury and pu nis Claim is 	irsuant to true and	the lav	ws of the State . signature*	e of lowa that the information

https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.



Rule 12.36—Form 15: Notice of Appointment of Mental Health Advocate

In the Iowa District Court for _	County where Notice is filed
In the Matter of	No
Respondent Full name: first, middle, last	Notice of Appointment of Mental Health Advocate
Alleged to be Seriously Mentally Impaired	Iowa Code § 229.19(1)(c)
To: Name of Respondent	
You are notified that	has been appointed
your Mental Health Advocate. Your Advocate representing your interests in this proceeding treatment.	g ,
Signature	
$\underline{\underline{Month}}$ $\underline{\underline{Day}}$, $20\underline{\underline{Year}}$ /\$/ $\underline{\underline{Clerk'}}$	s signature