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 a Person with a Substance-Related Disorder**	No._____ **Application Alleging Substance-Related Disorder** Iowa Code § 125.75

1. I, _____, allege Respondent is suffering from
Full name: first, middle, last
a substance-related disorder.

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 a substance-related disorder. ☐ 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 and surgeon or osteopathic physician and surgeon or mental health processional.

B. ☐ One or more Affidavits corroborating these allegations. *See Rule 13.35—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 13.35—Form 2: ***Affidavit in Support of Application Alleging Substance-Related Disorder***

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 a Person with a Substance-Related Disorder**	No._____ **Affidavit in Support of Application Alleging Substance-Related Disorder** Iowa Code § 125.75

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 a person with a substance-related disorder. 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.*

Rule 13.35—Form 3: ***Application for Appointment of Counsel for Respondent and Financial Statement***

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 a Person with a Substance-Related Disorder**	No._____ **Application for Appointment of Counsel for Respondent and Financial Statement** Iowa Code § 125.78

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

and 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 have 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, average 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:*	$
(12) Totals from attached pages, if any ☐ *Check this box if you have 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.*

Rule 13.35—Form 4: ***Application for Appointment of Counsel for Applicant and Financial Statement***

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 a Person with a Substance-Related Disorder**	No._____ **Application for Appointment of Counsel for Applicant and Financial Statement** Iowa Code §§ 125.76, .78

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

the Applicant in this case, and pursuant to Iowa Code sections 125.76 and 125.78(2), I request the court appoint counsel to represent me at public expense because I am financially unable to employ counsel.

2. Applicant's information

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

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

_____ _____
Marital status *Number of dependents*

B. Applicant's age: _____.

C. Applicant's employment status:

☐ Full-time

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

☐ Unemployed

3. Applicant's income

A. Income currently received by Applicant, before taxes and deductions:

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

Average current income for Applicant	**Income**	
	How often received?* *W, B, M, Y*	**Amount**
(1) Wages from employer *Employer name:* *Job title:*		$

Continued on next page

(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 sheets, if any ☐ *Check this box if you have attached additional pages regarding income sources.*		$
Total *Total income received by Applicant*		**$**

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

C. Is Applicant's spouse working? ☐ Yes ☐ No
If yes, average wages before taxes and deductions: $_____
per: ☐ hour ☐ month ☐ year

Continued on next page

4. Applicant'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. Applicant's debts

Debts and liabilities of Applicant	**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 sheets, if any ☐ *Check this box if you attached additional pages regarding debts and liabilities.*	$
Total	**$**

6. Applicant'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:*	$
(12) Totals from attached pages, if any ☐ *Check this box if you have 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 a Person with a Substance-Related Disorder**	No._____ **Physician's Report of Examination** Iowa Code § 125.80 Iowa Ct. R. 13.13

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 125.80? ☐ Yes ☐ No

4. Did facility personnel assist with this exam? ☐ Yes ☐ No

If yes, provide that person's name: _____
Facility personnel's name

_____ _____. _____ _____
Business address *City* *State* *ZIP code*

Attach the facility personnel's report, if written

Continued on next page

5. In your judgment, is Respondent a person with a substance-related disorder as defined by the American Psychiatric Association? ☐ 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 a danger to self or others and lacks judgmental capacity due to a substance-related disorder? ☐ 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.*

7. 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.*

8. Can Respondent be evaluated on an outpatient basis? ☐ Yes ☐ No
Basis for answer

_____

_____

_____

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

9. 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
Basis for answer

_____

_____

_____

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

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

Continued on next page

11. Does Respondent have a prior history of other substance-related disorders or physical or mental illness? ☐ Yes ☐ No

If yes, specify

_____

_____

_____

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

12. 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.*

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.*

***The Report of Examination must be filled out by a court-designated licensed physician and surgeon or osteopathic physician and surgeon or mental health professional. Iowa Code § 125.80(2).*

Rule 13.35—Form 6: ***Stipulation Regarding Respondent's Presence***

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 a Person with a Substance-Related Disorder**	No._____ **Stipulation Regarding Respondent's Presence** Iowa Code § 125.82 Iowa Ct. R. 13.19(2)

1. I, _____, I am an attorney representing Respondent in this matter and stipulate that Respondent need not be present at the hearing to determine whether Respondent is a person with a substance-related disorder.
Full name: first, middle, last

2. On, _____ ____, 20___, I conversed with Respondent about the hearing and Respondent's absence from the hearing.
Month *Day* *Year*

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*

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 a Person with a Substance-Related Disorder**	No._____ **Notice of Medication** Iowa Code § 125.82(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 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 13.35—Form 8: ***Application for Extension of Time for Evaluation***

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 a Person with a Substance-Related Disorder**	No._____ **Application for Extension of Time for Evaluation** Iowa Code § 125.83

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 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 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 a Person with a Substance-Related Disorder**	No._____ **Report of Substance Abuse Evaluation** Iowa Code § 125.84 Iowa Ct. R. 13.24

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

and for the Report of Substance Abuse 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. In your opinion, is Respondent a person with a substance-related disorder as defined by the American Psychiatric Association? ☐ 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

6. 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.*

7. In your opinion, does Respondent have the capacity to understand the need for treatment? ☐ Yes ☐ No

If no, state basis for answer

_____

_____

_____

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

8. In your opinion, is Respondent a danger to self or others and lacks judgmental capacity due to a substance-related disorder? ☐ 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. Proposed treatment and placement

In your opinion,

Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for substance abuse. Iowa Code § 125.84(1).

B. ☐ Respondent is a person with a substance-related disorder and in need of full-time custody, care, and treatment in a facility and is likely to benefit from treatment. Iowa Code § 125.84(2).

Recommended further treatment:

_____

_____

_____

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

Continued on next page

C. ☐ Respondent is a person with a substance-related disorder and in need of treatment but does not require full-time placement in a facility. Iowa Code § 125.84(3).

Recommended treatment on an outpatient or other appropriate basis:

_____

_____

_____

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

D. ☐ Respondent is a person with a substance-related disorder and in need of treatment but is not responding to the treatment provided. Iowa Code § 125.84(4).

Recommended alternative placement:

_____

_____

_____

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

10. 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.*

11. 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 Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be a Person with a Substance-Related Disorder**	No._____ **Periodic Report (Respondent Inpatient)** Iowa Code § 125.86(1)

1. I,_____, of _____,
Full name *Hospital or facility*
and for the Periodic Report of Respondent, state the following.

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

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

_____

_____

_____

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

4. In the opinion of the chief medical officer, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

_____

_____

_____

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

5. In your opinion, is Respondent a person with a substance-related disorder as defined by the American Psychiatric Association? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts and symptoms

_____

_____

_____

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

Continued on next page

6. 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.*

7. In your opinion, does Respondent have the capacity to understand the need for treatment? ☐ Yes ☐ No

If no, state basis for answer

_____

_____

_____

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

8. In your opinion, is Respondent a danger to self or others and lacks judgmental capacity due to a substance-related disorder? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

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

9. Proposed treatment and placement

In your opinion,

Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for substance abuse. Iowa Code § 125.84(1).

Explanation

_____

_____

_____

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

STOP *If you checked **9**(A), stop and sign below.*

Continued on next page

B. ☐ Respondent is a person with a substance-related disorder and in need of full-time custody, care, and treatment in a facility and is considered likely to benefit from treatment. Iowa Code § 125.84(2).

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

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommended further treatment:

_____

_____

_____

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

C. ☐ Respondent is a person with a substance-related disorder and in need of treatment but does not require full-time placement in a facility. Iowa Code § 125.84(3).

Recommended treatment on an outpatient or other appropriate basis:

_____

_____

_____

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

D. ☐ Respondent is a person with a substance-related disorder and in need of treatment but is not responding to the treatment provided. Iowa Code § 125.84(4).

Recommended alternative placement:

_____

_____

_____

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

10. 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

11. 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 Report is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be a Person with a Substance-Related Disorder**	No._____ **Periodic Report (Respondent Outpatient)** Iowa Code § 125.86(2)

1. I,_____, of _____,
Full name *Hospital or facility*
and for the Periodic Report of Respondent, state the following.

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

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

_____

_____

_____

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

4. In the opinion of the chief medical officer, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

_____

_____

_____

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

5. In your opinion, is Respondent a person with a substance-related disorder as defined by the American Psychiatric Association? ☐ Yes ☐ No
If yes, state diagnosis including supporting facts and symptoms

_____

_____

_____

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

Continued on next page

6. 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.*

7. In your opinion, does Respondent have the capacity to understand the need for treatment? ☐ Yes ☐ No

If no, state basis for answer

_____

_____

_____

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

8. In your opinion, is Respondent a danger to self or others and lacks judgmental capacity due to a substance-related disorder? ☐ Yes ☐ No

If yes, state basis for answer

_____

_____

_____

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

9. Proposed treatment and placement

In your opinion,

Check one

A. ☐ Respondent does not, as of the date of this Report, require further treatment for substance abuse. Iowa Code § 125.84(1).

Explanation

_____

_____

_____

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

STOP *If you checked **9**(A), stop and sign below.*

Continued on next page

B. ☐ Respondent is a person with a substance-related disorder and in need of full-time custody, care, and treatment in a facility and is considered likely to benefit from treatment. Iowa Code § 125.84(2).

Recommended further treatment:

_____

_____

_____

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

C. ☐ Respondent is a person with a substance-related disorder and in need of treatment but does not require full-time placement in a facility. Iowa Code § 125.84(3).

(1) Estimated further length of time Respondent will require treatment on an outpatient or other appropriate basis:
Check one

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommended further treatment:

_____

_____

_____

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

D. ☐ Respondent is a person with a substance-related disorder and in need of treatment but is not responding to the treatment provided. Iowa Code § 125.84(4).

Recommended alternative placement:

_____

_____

_____

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

10. 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

11. 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*

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***A **psychiatric advanced registered nurse practitioner** treating Respondent may complete this Periodic Report. Iowa Code § 125.86(3)*(a).

*An **advanced registered nurse practitioner** who is not certified as a psychiatric advanced registered nurse practitioner but who meets the qualifications of a mental health professional may complete this Periodic Report. Iowa Code § 125.86(3)*(b).

Rule 13.35—Form 12: ***Report of Respondent's Discharge***

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 a Person with a Substance-Related Disorder**	No._____ **Report of Respondent's Discharge** Iowa Code § 125.85(4)

I, _____, administer of _____,
Name *Facility*

inform the court that Respondent was discharged from this facility or treatment on

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

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.*

Rule 13.35—Form 13: ***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 a Person with a Substance-Related Disorder**	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 a person with a substance-related disorder, 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.*

Rule 13.35—Form 14a: ***Claim for Attorney Fees***

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

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be a Person with a Substance-Related Disorder**	No._____ **Claim for Attorney Fees** Iowa Code § 125.78(1)

1. I, the undersigned attorney, state that the court appointed me to represent Respondent, alleged to be a person with a substance-related disorder, pursuant to Iowa Code section 125.78(1), 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 125.78(1).

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 a Person with a Substance-Related Disorder**	No._____ **Claim for Physician Fees** Iowa Code § 125.80(1)

1. I, the undersigned physician, state that pursuant to Iowa Code section 125.80(1), I examined Respondent, alleged to be a person with a substance-related disorder, 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 125.80(1).

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**

_____ _____, _____ _____
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.*