# CHAPTER 12
# RULES FOR INVOLUNTARY HOSPITALIZATION OF MENTALLY ILL PERSONS


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# CHAPTER 12
# RULES FOR INVOLUNTARY HOSPITALIZATION OF MENTALLY ILL PERSONS

[Forms included at rule 12.36]
*See* Iowa Code section 229.40

**Rule 12.1 Application.**

**12.1(1)** An application seeking the involuntary hospitalization or treatment of any person on grounds of serious mental impairment may be obtained from any district court clerk in any county. Such application may be filled out and presented to the clerk by any person who has an interest in the treatment of another for serious mental impairment and who has sufficient contact with or knowledge about that person to provide the information required on the face of the application and by Iowa Code section 229.6. The clerk or clerk's designee shall provide the forms required by Iowa Code section 229.6 to the person who desires to file the application for involuntary commitment. The clerk shall see that all the necessary information required by Iowa Code section 229.6 accompanies the application.

**12.1(2)** A verified application may be filed with the district court clerk in any county. If the application is not filed in a county where the respondent is located or resides, then the court shall transfer jurisdiction of the case to the county where the respondent is located or that is the respondent's place of residence in accordance with Iowa Code section 229.6(1)(*b*).

[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002; August 22, 2025, effective October 21, 2025]

**Rule 12.2 Termination of proceedings — insufficient grounds.** If the judge or referee determines that insufficient grounds to warrant a hearing on the respondent's serious mental impairment appear on the face of the application and supporting documentation, the judge or referee shall order the proceedings terminated, so notify the applicant, and all papers and records pertaining thereto shall be confidential and subject to the provisions of Iowa Code section 229.24.

[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.3 Notice to respondent — requirements.**

**12.3(1)** If the judge or referee determines that sufficient grounds to warrant a hearing on the respondent's serious mental impairment appear on the face of the application and supporting documentation, the sheriff or sheriff's deputy shall immediately serve notice, personally and not by substitution, on the respondent. Pursuant to Iowa Code section 229.9, notice shall also be served on respondent's attorney as soon as the attorney is identified or appointed by the judge or referee.

**12.3(2)** If the respondent is being taken into immediate custody pursuant to Iowa Code section 229.11, the notice shall include a copy of the order required by section 229.11 and rule 12.14.

**12.3(3)** The notice of procedures required under Iowa Code section 229.7 shall inform the respondent of the following:

*a.* The respondent's immediate right to counsel, at county expense if necessary.

*b.* The right to request an examination by a physician of the respondent's choosing, at county expense if necessary.

*c.* The right to be present at the hearing.

*d.* The right to a hearing within five days if the respondent is taken into immediate custody pursuant to Iowa Code section 229.11.

*e.* The right not to be forced to hearing sooner than forty-eight hours after notice, unless respondent waives such minimum prior notice requirement.

*f.* The respondent's duty to remain in the jurisdiction and the consequences of an attempt to leave.

*g.* The respondent's duty to submit to examination by a physician appointed by the court.

[Supreme Court Report 1979; amendment 1982; November 9, 2001, effective February 15, 2002]

**Rule 12.4 Notice requirement — waiver.** The respondent may waive the minimum prior notice requirement only in writing and only if the judge or referee determines that the respondent's best interests will not be harmed by such waiver.

[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.5 Hearings — continuance.** At the request of the respondent or the respondent's attorney, the hearing provided in Iowa Code section 229.12 may be continued beyond the statutory limit in order that the respondent's attorney has adequate time to prepare for the case, and in such instances custody pursuant to Iowa Code section 229.11 may be extended by court order until the hearing is held. The continuance shall be no longer than five days beyond the statutory limit, unless respondent gives written consent to the longer continuance.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.6 Attorney conference with respondent — location — transportation.** If the respondent is involuntarily confined prior to the hearing pursuant to a determination under Iowa Code section 229.11, the respondent's attorney may apply to the judge or referee for an opportunity to confer with the respondent, in a place other than the place of confinement, in advance of the hearing provided for in Iowa Code section 229.12. The order shall provide for transportation and the type of custody and responsibility therefor during the period the respondent is away from the place of confinement under this rule.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.7 Service, other than personal.** If personal service as defined in rule 12.3 cannot be made, any respondent may be served as provided by court order, consistent with due process of law.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.8 Return of service.** Returns of service of notice shall be made as provided in Iowa R. Civ. P. 1.308.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.9 Amendment of proof of service.** Amendment of process or proof of service shall be allowed in the manner provided in Iowa R. Civ. P. 1.309.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.10 Attorney evidence and argument — predetermination.** If practicable the court should allow the respondent's attorney to present evidence and argument prior to the judge's determination under Iowa Code section 229.11.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.11 Attorney evidence and argument — after confinement.** If the respondent's attorney is afforded no opportunity to present evidence and argument prior to the determination under Iowa Code section 229.11, the attorney shall be entitled to do so after the determination during the course of respondent's confinement pursuant to an order issued under that section.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.12 Examination report to attorney.** The clerk shall furnish the respondent's attorney with a copy of the examination report filed pursuant to Iowa Code section 229.10(2), as soon as possible after receipt. In ruling on any request for an extension of time under Iowa Code section 229.10(4), the court shall consider the time available to the respondent's attorney after receipt of the examination report to prepare for the hearing and to prepare responses from physicians engaged by the respondent, where relevant. Respondent's attorney shall promptly file a copy of a report of any physician who has examined respondent and whose evidence the attorney expects to use at the hearing. The clerk shall provide the court and the county attorney with a copy thereof when filed.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.13 Physician's report.** The court-designated physician shall submit a written report of the examination as required by Iowa Code section 229.10(2) on the form designated for use by the supreme court. The report shall contain the following information, or as much thereof as is available to the physician making the report:

(1) Respondent's name;
(2) Address;
(3) Date of birth;

(4) Place of birth;
(5) Sex;
(6) Occupation;
(7) Marital status;
(8) Number of children, and names;
(9) Nearest relative's name, relationship, and address; and
(10) The physician's diagnosis and recommendations with a detailed statement of the facts, symptoms and overt acts observed or described to the physician, which led to the diagnosis.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.14 Probable cause.** The judge's or referee's immediate custody order under Iowa Code section 229.11 shall include a finding of probable cause to believe that the respondent is seriously mentally impaired and is likely to inflict self-injury or injure others if allowed to remain at liberty.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.15 Hearing — county location.** The hearing provided in Iowa Code section 229.12 shall be held in the county where the application was filed unless the judge or referee finds that the best interests of the respondent would be served by transferring the proceedings to a different location. If the application was filed in a county where the respondent was not located and did not reside and the court transferred jurisdiction of the case to a county where the respondent was located or residing pursuant to Iowa Code section 229.6(1)(*b*), then the hearing shall be held in the county where the case was transferred to.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002; August 22, 2025, effective October 21, 2025]

**Rule 12.16 Hearing — location at hospital or treatment facility.** The hearing required by Iowa Code section 229.12 may be held at a hospital or other treatment facility, provided a proper room is available and provided such a location would not be detrimental to the best interests of the respondent.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.17 Respondent's rights explained before hearing.** The respondent's rights as set out in rule 12.3(3) and the possible consequences of the procedures shall be explained to the respondent by the respondent's attorney to the extent possible. Prior to the commencement of the hearing under Iowa Code section 229.12, the judge or referee shall ascertain whether the respondent has been so informed.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.18 Subpoenas.** Subpoena power shall be available to all parties participating in the proceedings, and subpoenas or other investigative demands may be enforced by the judge or referee.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.19 Presence at hearing — exceptions.**

**12.19(1)** The person(s) filing the application and any physician or mental health professionals who have examined respondent and have submitted a written examination of the respondent in connection with the hospitalization proceedings must be present at the hearing conducted under Iowa Code section 229.12 unless their presence is waived by the respondent's attorney, the judge or referee finds their presence is not necessary, or their testimony can be taken through telephonic means and the respondent's attorney does not object.

**12.19(2)** The respondent must be present at the hearing unless prior to the hearing the respondent's attorney stipulates in writing to respondent's absence, such stipulation to state that the attorney has conversed with the respondent, that in the attorney's judgment the respondent can make no meaningful contribution to the hearing, and the basis for such conclusions. A stipulation to the respondent's absence shall be reviewed by the judge or referee before the

hearing, and may be rejected if it appears that insufficient grounds are stated or that the respondent's interests would not be served by respondent's absence.
[Supreme Court Report 1979; amendment 1980; October 11, 1991, effective January 2, 1992; November 9, 2001, effective February 15, 2002]

**Rule 12.20 Hearing — electronic recording.** An electronic recording or other verbatim record of the hearing provided in Iowa Code section 229.12 shall be made and retained for three years or until the respondent has been discharged from involuntary custody for 90 days, whichever is longer.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.21 Transfer from county of confinement.** If the respondent is in custody in another county prior to the hearing provided in Iowa Code section 229.12, respondent's attorney may request that the respondent be delivered to the county in which the hearing will be held prior thereto in order to facilitate preparation by respondent's attorney. Such requests should be denied only if they are unreasonable and if the denial would not harm respondent's interests in representation by counsel. This rule is not intended to authorize permanent transfer of the respondent to another facility without conformance to appropriate statutory procedures.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.22 Evaluation and treatment.** If the respondent is found by the court to be seriously mentally impaired following a hearing under Iowa Code section 229.12, evaluation and treatment shall proceed as set out in Iowa Code section 229.13.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.23 Evaluation — time extension.** If, pursuant to Iowa Code section 229.13, the chief medical officer requests an extension of time for evaluation beyond 15 days, the chief medical officer shall file application in the form prescribed by this chapter with the clerk of court in the county in which the hearing was held. The application shall contain a statement by the chief medical officer or the officer's designee identifying with reasonable particularity the facts and reasons in support of the request for extension. The clerk shall immediately notify the respondent's attorney of the request and shall furnish a copy of the application to the attorney. The clerk shall also immediately furnish a copy of the application to the respondent's advocate, if one has been appointed.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.24 Evaluation report.** The findings of the chief medical officer pursuant to Iowa Code section 229.14 must state with reasonable particularity on the form prescribed by this chapter the facts and basis for the diagnostic conclusions concerning the respondent's serious mental impairment and recommended treatment, including but not limited to: The basis for the chief medical officer's conclusion as to respondent's mental illness, judgmental capacity concerning need for treatment, treatability, and dangerousness; and the basis for the chief medical officer's conclusions concerning recommended treatment including the basis for the judgment that the chief medical officer's treatment recommendation is the least restrictive alternative treatment pursuant to options (*a*), (*b*), (*c*), or (*d*) of Iowa Code section 229.14(1).
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002; October 1, 2008, effective December 15, 2008]

**Rule 12.25 Reports issued by clerk.** The clerk shall promptly furnish copies of all reports issued under Iowa Code section 229.15 to the patient's attorney or advocate or to both if they both are serving in their respective capacities at the same time, and such reports shall comply substantially with the requirements of rule 12.24.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.26 Clerk's filing system.** The clerk shall institute an orderly system for filing periodic reports required under Iowa Code section 229.15 and shall in timely fashion ascertain when a report is overdue. In the event a report is not filed, the clerk shall contact the chief medical officer of the treatment facility and obtain a report.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.27 Emergency detention — magistrate's approval.** If the magistrate does not immediately proceed to the facility where a person is detained pursuant to Iowa Code section 229.22, the magistrate shall verbally communicate approval or disapproval of the detention and such communication shall be duly noted by the chief medical officer of the facility on the form prescribed by this chapter.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.28 Emergency detention — medical officer absent from facility.** If the facility to which the respondent is delivered pursuant to Iowa Code section 229.22 lacks a chief medical officer, the person then in charge of the facility shall, if treatment appears necessary to protect the respondent, immediately notify a physician. The person in charge of the facility shall then immediately notify the magistrate.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.29 Attorney appointed.** As soon as practicable after the respondent's delivery to a facility under Iowa Code section 229.22, the magistrate shall identify or appoint an attorney for the respondent and shall immediately notify such attorney of respondent's emergency detention. If counsel can be identified at the time of respondent's arrival at a facility, or if legal services are available through a legal aid or public defender office, the magistrate must immediately notify such counsel and such counsel shall be afforded an opportunity to see the respondent and to make such preparation as is appropriate before or after the magistrate's order is issued.
[Supreme Court Report 1979; November 9, 2001, effective February 15, 2002]

**Rule 12.30 Chemotherapy procedure.** When chemotherapy has been instituted prior to a hearing under Iowa Code section 229.12, the chief medical officer of the facility where the respondent is hospitalized shall, prior to the hearing, submit to the clerk of the district court where the hearing is to be held, a report in writing listing all types of chemotherapy given for purposes of affecting the respondent's behavior or mental state during any period of custody authorized by Iowa Code section 229.4(3), 229.11 or 229.22. For each type of chemotherapy the report shall indicate either the chemotherapy was given with the consent of the patient or the patient's next of kin or guardian or the way the chemotherapy was "necessary to preserve the patient's life or to appropriately control behavior by the person which is likely to result in physical injury to that person or others if allowed to continue." The report shall also include the effect of the chemotherapy on the respondent's behavior or mental state. The clerk shall file the original report in the court file, advise the judge or referee and the respondent's attorney accordingly and provide a copy of the report to respondent's attorney if so requested.
[Supreme Court Report 1979; amendment 1980; November 9, 2001, effective February 15, 2002]

**Rule 12.31 Outpatient treatment plan.** If, pursuant to Iowa Code section 229.14(3), the chief medical officer determines that the patient is suited for outpatient care, the chief medical officer (or a designee) shall determine the specific care and treatment guidelines upon which the outpatient status will be based and shall discuss these guidelines with the patient. These written guidelines shall be known as the Outpatient Treatment Plan (O.T.P.). If the chief medical officer (or a designee) alleges that the O.T.P. has been breached, the judge or a judicial hospitalization referee shall hold a hearing as provided by Iowa Code sections 229.14(3) and 229.12 to determine whether the patient should be rehospitalized, whether the O.T.P. should be revised, or whether some other remedy should be ordered. The patient shall be given reasonable notice of such a hearing.
[Supreme Court Report 1982; amendment 1983; November 9, 2001, effective February 15, 2002]

**Rules 12.32** to **12.35** Reserved.

## Rule 12.36 Forms for involuntary hospitalization of mentally ill persons.

**Rule 12.36—Form 1:** ***Application Alleging Serious Mental Impairment (Involuntary Commitment)***

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Application Alleging Serious Mental Impairment (Involuntary Commitment)**<br><br>Iowa Code § 229.6 |

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

**2.** Respondent is presently located in _____ County and
*County name*
resides in _____ County.
*County name*

**3.** In support of this Application, I state:

_____

_____

_____

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

**4.** 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

**5.** I request that:
*Check one*

A. ☐ Respondent be taken into immediate custody.

B. ☐ Respondent not be taken into immediate custody.

**6.** 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* ***6****(A) or* ***6****(B).*

***Continued on next page***

Rule 12.36—Form 1: *Application Alleging Serious Mental Impairment (Involuntary Commitment)*, continued

## 7. 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*

## 8. 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.*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024; August 22, 2025, effective October 21, 2025; August 31, 2026, effective October 30, 2026]

**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**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Affidavit in Support of Application Alleging Serious Mental Impairment**<br><br>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.*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**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<br>*Employer name:*<br>*Job title:* | | $ |
| (2) Wages from employer<br>*Employer name:*<br>*Job title:* | | $ |
| (3) Unemployment assistance | | $ |
| (4) Family Investment Program | | $ |
| (5) Social Security | | $ |
| (6) Other<br>*Identify:* | | $ |
| (7) Other<br>*Identify:* | | $ |
| (8) Other<br>*Identify:* | | $ |
| (9) Totals from attached pages, if any<br>☐ *Check this box if you attached additional pages regarding income sources.* | | $ |
| **Total**<br>*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<br>Amount |
|---|---|
| (1) Mortgage | $ |
| (2) Car loan | $ |
| (3) Credit card debt | $ |
| (4) Other<br>*Identify:* | $ |
| (5) Other<br>*Identify:* | $ |
| (6) Other<br>*Identify:* | $ |
| (7) Totals from attached pages, if any<br>☐ *Check this box if you attached additional pages regarding debts and liabilities.* | $ |
| **Total** | **$** |

## 6. Respondent's expenditures

| Type of expense | Amount<br>*Check one*<br>☐ 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<br>*Identify:* | $ |
| (10) Other expense<br>*Identify:* | $ |
| (11) Other expense<br>*Identify:* | $ |
| (12) Totals from attached pages, if any<br>☐ *Check this box if you attached additional pages regarding expenses.* | $ |
| **Total**<br>*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.*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**Rule 12.36—Form 4:** ***Physician or Mental Health Professional's Report of Examination***

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

| | |
|---|---|
| **In the Matter of**<br>_____,<br>**Respondent** *Full name: first, middle, last*<br>**Alleged to be Seriously Mentally Impaired** | No._____<br>**Physician or Mental Health Professional's Report of Examination**<br>Iowa Code § 229.10<br>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 229.10? ☐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***

Rule 12.36—Form 4: *Physician or Mental Health Professional's Report of Examination*, continued

**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 likely to 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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**Rule 12.36—Form 5: *Stipulation Regarding Respondent's Presence***

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Stipulation Regarding Respondent's Presence**<br><br>Iowa Code § 229.12<br>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 a**nd 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*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of** | No._____ |
| _____, | **Notice of Medication** |
| **Respondent** *Full name: first, middle, last* | |
| **Alleged to be Seriously Mentally Impaired** | 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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Application for Extension of Time for Psychiatric Evaluation**<br><br>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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Chief Medical Officer's Report of Psychiatric Evaluation**<br><br>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 likely to 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***

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

**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) 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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Chief Medical Officer's Periodic Report (Respondent Inpatient)**<br><br>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 on _____ ____, 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) 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***

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

**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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**Rule 12.36—Form 10:** ***Periodic Report (Respondent Outpatient)***

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Periodic Report (Respondent Outpatient)**<br><br>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 on _____ ____, 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) 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***

Rule 12.36—Form 10: *Periodic Report (Respondent Outpatient)*, continued

**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*

**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**).*

*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**).*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Periodic Report (Alternative Facility Placement)**<br><br>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 on
_____ _____, 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) 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*

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[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**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**<br><br>**_____,**<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee**<br><br>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.*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024 effective July 1, 2024]

**Rule 12.36—Form 13:** ***Attorney's Motion to Withdraw***

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Attorney's Motion to Withdraw**<br><br>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*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**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**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Claim for Attorney Fees**<br><br>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 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 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*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

**Rule 12.36—Form 14b: *Claim for Physician Fees***

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

| | |
|---|---|
| **In the Matter of**<br><br>_____,<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Claim for Physician Fees**<br><br>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 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 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.*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]

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

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

| | |
|---|---|
| **In the Matter of**<br><br>**_____,**<br>**Respondent** *Full name: first, middle, last*<br><br>**Alleged to be Seriously Mentally Impaired** | No._____<br><br>**Notice of Appointment of Mental Health Advocate**<br><br>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*



[Court Order August 17, 2022, effective November 1, 2022; April 29, 2024, effective July 1, 2024]