

In the Iowa Supreme Court

**In the Matter of Adopting Revised
Iowa Court Rules Chapter 12 and
Chapter 13 Forms Relating to
Involuntary Hospitalizations and
Commitments**

Order


The supreme court adopts revised court forms for chapter 12, involuntary hospitalization of mentally ill persons, and chapter 13, involuntary commitment or treatment of persons with substance-related disorders, of the Iowa Court Rules provided with this order. The revised forms have been updated to conform with current Iowa Code provisions, improve formatting, and streamline language. Additionally, outdated forms have been removed and the forms in both chapters have been renumbered.

The supreme court removes all existing rule 12.36 and rule 13.35 forms and replaces them with the forms provided with this order. Included with this order are lists outlining the new names and numbering of the forms for each chapter.

Subject to Iowa Legislative Council review consistent with the provisions of Iowa Code section 602.4202, the prior chapter 12 and chapter 13 forms will expire and the new forms provided with this order will become effective on November, 1, 2022.

Dated this 17th day of August, 2022.

The Iowa Supreme Court

By: 

Susan Larson Christensen, Chief Justice



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

In the Matter of

No. _____

Respondent *Full name: first, middle, last*

Application Alleging Substance-Related Disorder

Alleged to be a Person with a 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 professional.
- 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:*

<i>Name of attorney or organization, if any</i>	<i>Attorney's PIN – Ask the attorney</i>
<i>Business address of attorney or organization</i>	<i>City</i> <i>State</i> <i>ZIP code</i>
(____) _____	_____
<i>Attorney's phone number</i>	<i>Attorney's email address – optional</i>

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**

<i>Mailing address</i>	<i>City</i> <i>State</i> <i>ZIP code</i>
(____) _____	_____
<i>Phone number</i>	<i>Email address</i> <i>Additional email address, if applicable</i>

**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 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:

Multiple horizontal lines for providing supporting information.

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.

Month Day, 20 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.



FILED

AUG 17 2022

CLERK SUPREME COURT

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?*	Amount
	<i>W, B, M, Y</i>	
(1) Wages from employer <i>Employer name:</i> <i>Job title:</i>		\$
(2) Wages from employer <i>Employer name:</i> <i>Job title:</i>		\$
(3) Unemployment assistance		\$
(4) Family Investment Program		\$
(5) Social Security		\$
(6) Other <i>Identify:</i>		\$
(7) Other <i>Identify:</i>		\$
(8) Other <i>Identify:</i>		\$
(9) Totals from attached pages, if any <input type="checkbox"/> <i>Check this box if you have attached additional pages regarding income sources.</i>		\$
Total <i>Total income received by Respondent</i>		\$

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 <i>What it would sell for</i>	Debt <i>Total amount owed on debt and to whom owed</i>	Net value <i>Market value minus debt owed</i>
(1) Homestead <i>Address</i>	<input type="checkbox"/>	\$	\$ to:	\$
(2) Other real estate <i>Address</i>	<input type="checkbox"/>	\$	\$ to:	\$

Check this box if you have attached additional pages.

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

Vehicle <i>Make (e.g., Ford), model, year</i>	Jointly owned?	Market value <i>What it would sell for</i>	Debt <i>Total amount owed on debt and to whom owed</i>	Net Value <i>Market value minus debt owed</i>
(1)	<input type="checkbox"/>	\$	\$ to:	\$
(2)	<input type="checkbox"/>	\$	\$ to:	\$
(3)	<input type="checkbox"/>	\$	\$ 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 <i>Identify:</i>	\$
(5) Other <i>Identify:</i>	\$
(6) Other <i>Identify:</i>	\$
(7) Totals from attached pages, if any <input type="checkbox"/> <i>Check this box if you attached additional pages regarding debts and liabilities.</i>	\$
Total	\$

6. Respondent’s expenditures

Type of expense	Amount <i>Check one</i> <input type="checkbox"/> monthly <input type="checkbox"/> annual
(1) House payment or rent	\$
(2) Food	\$
(3) Insurance (<i>health, dental, auto, etc.</i>)	\$
(4) Utilities (<i>gas, electric, water, internet, etc.</i>)	\$
(5) Phone	\$
(6) Child support payments	\$
(7) Car payment	\$

Continued on next page



(8) Credit card payments	\$
(9) Other expense <i>Identify:</i>	\$
(10) Other expense <i>Identify:</i>	\$
(11) Other expense <i>Identify:</i>	\$
(12) Totals from attached pages, if any <input type="checkbox"/> <i>Check this box if you have attached additional pages regarding expenses.</i>	\$
Total <i>Total expenditures</i>	\$

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

FILED
 AUG 17 2022

CLERK SUPREME COURT

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?*	Amount
	<i>W, B, M, Y</i>	
(1) Wages from employer <i>Employer name:</i> <i>Job title:</i>		\$

Continued on next page



(1) Wages from employer <i>Employer name:</i> <i>Job title:</i>		\$
(2) Wages from employer <i>Employer name:</i> <i>Job title:</i>		\$
(3) Unemployment assistance		\$
(4) Family Investment Program		\$
(5) Social Security		\$
(6) Other <i>Identify:</i>		\$
(7) Other <i>Identify:</i>		\$
(8) Other <i>Identify:</i>		\$
(9) Totals from attached sheets, if any <input type="checkbox"/> <i>Check this box if you have attached additional pages regarding income sources.</i>		\$
Total <i>Total income received by Applicant</i>		\$

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 <i>What it would sell for</i>	Debt <i>Total amount owed on debt and to whom owed</i>	Net value <i>Market value minus debt owed</i>
(1) Homestead <i>Address</i>	<input type="checkbox"/>	\$	\$ to:	\$
(2) Other real estate <i>Address</i>	<input type="checkbox"/>	\$	\$ to:	\$

Check this box if you have attached additional pages.

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

Vehicle <i>Make (e.g., Ford), model, year</i>	Jointly owned?	Market value <i>What it would sell for</i>	Debt <i>Total amount owed on debt and to whom owed</i>	Net Value <i>Market value minus debt owed</i>
(1)	<input type="checkbox"/>	\$	\$ to:	\$
(2)	<input type="checkbox"/>	\$	\$ to:	\$
(3)	<input type="checkbox"/>	\$	\$ 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 <i>Identify:</i>	\$
(5) Other <i>Identify:</i>	\$
(6) Other <i>Identify:</i>	\$
(7) Totals from attached sheets, if any <input type="checkbox"/> <i>Check this box if you attached additional pages regarding debts and liabilities.</i>	\$
Total	\$

6. Applicant's expenditures

Type of expense	Amount <i>Check one</i> <input type="checkbox"/> monthly <input type="checkbox"/> annual
(1) House payment or rent	\$
(2) Food	\$
(3) Insurance (<i>health, dental, auto, etc.</i>)	\$
(4) Utilities (<i>gas, electric, water, internet, etc.</i>)	\$
(5) Phone	\$
(6) Child support payments	\$
(7) Car payment	\$

Continued on next page



(8) Credit card payments	\$
(9) Other expense <i>Identify:</i>	\$
(10) Other expense <i>Identify:</i>	\$
(11) Other expense <i>Identify:</i>	\$
(12) Totals from attached pages, if any <input type="checkbox"/> <i>Check this box if you have attached additional pages regarding expenses.</i>	\$
Total <i>Total expenditures</i>	\$

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 _____,

No. _____

Respondent *Full name: first, middle, last*

Physician's Report of Examination

Alleged to be a Person with a Substance-Related Disorder

Iowa Code § 125.80
Iowa Ct. R. 13.13

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

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).*



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.
2. On, _____, 20____, I conversed with Respondent about the hearing and Respondent's absence from the hearing.
3. In my judgment,
A. Respondent can make no meaningful contribution to the hearing.
B. Respondent has waived the right to be present at the hearing.
I base this judgment on the following grounds:

Check this box if you have attached additional pages.

4. Attorney's signature

Printed name /s/ Signature

Law firm, if applicable

Mailing address

City State ZIP code

Phone number Attorney PIN number

Email address Additional email address, if applicable

Month Day, 20 Year



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

In the Matter of

No. _____

Respondent *Full name: first, middle, last*

Notice of Medication

Alleged to be a Person with a Substance-Related Disorder

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.*



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

In the Matter of

No. _____

Respondent Full name: first, middle, last

Application for Extension of Time for Evaluation

Alleged to be a Person with a Substance-Related Disorder

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:

Four horizontal lines for providing reasons for the extension request.

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

Month Day, 20 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

No. _____

Respondent Full name: first, middle, last

Report of Substance Abuse Evaluation

Alleged to be a Person with a Substance-Related Disorder

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 _____:____
Month Day Year Time a.m. p.m.

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

No. _____

Respondent *Full name: first, middle, last*

**Periodic Report
(Respondent Inpatient)**

**Alleged to be a Person with a
Substance-Related Disorder**

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.

 *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

No. _____

Respondent *Full name: first, middle, last*

**Periodic Report
(Respondent Outpatient)**

**Alleged to be a Person with a
Substance-Related Disorder**

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

<i>Printed name</i>	<i>Signature*</i>	
<i>Title**</i>	<i>Name of facility</i>	
<i>Mailing address</i>		
<i>City</i>	<i>State</i>	<i>ZIP code</i>
(____) _____ <i>Phone number</i>		
<i>Email address</i>	<i>Additional email address, if applicable</i>	
_____, 20____		
<i>Month</i>	<i>Day</i>	<i>Year</i>

**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.*

***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).*



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/the-public/court-forms/>, or by printing and hand-signing.



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

In the Matter of _____,
Respondent *Full name: first, middle, last*
Alleged to be a Person with a
Substance-Related Disorder

No. _____

**Notice of Appeal from Findings of
Magistrate or Judicial Hospitalization
Referee**

Iowa Code § 229.21(3)

- To: The clerk of the district court for _____ County.
County where Notice is filed
- 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
- Respondent requests a review of this matter by a judge of the district court in accordance with Iowa Code section 229.21(3).

4. Signature

Printed name

*Signature**

Date: _____, 20____.
Month Day Year

Signed by:

Check one

- Respondent
- Attorney
- Next friend of Respondent
- Guardian of Respondent

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



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

In the Matter of

No. _____

Respondent *Full name: first, middle, last*

Claim for Attorney Fees

Alleged to be a Person with a Substance-Related Disorder

Iowa Code § 125.78(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.
- I request an order to be compensated in accordance with the provisions of Iowa Code section 125.78(1).
- 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.

CHAPTER 13
RULES FOR INVOLUNTARY HOSPITALIZATION OF MENTALLY ILL
PERSONS

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- Rule 13.35 Forms for Involuntary Commitment or Treatment of Persons with Substance-Related Disorders.
- Form 1: Application Alleging Substance-Related Disorder
 - Form 2: Affidavit in Support of Application Alleging Substance-Related Disorder
 - Form 3: Application for Appointment of Counsel for Respondent and Financial Statement
 - Form 4: Application for Appointment of Counsel for Applicant and Financial Statement
 - Form 5: Physician's Report of Examination
 - Form 6: Stipulation Regarding Respondent's Presence
 - Form 7: Notice of Medication
 - Form 8: Application for Extension of Time for Evaluation
 - Form 9: Report of Substance Abuse Evaluation
 - Form 10: Periodic Report (Respondent Inpatient)
 - Form 11: Periodic Report (Respondent Outpatient)
 - Form 12: Report of Respondent's Discharge
 - Form 13: Notice of Appeal from Findings of Magistrate or Judicial Hospitalization Referee
 - Form 14a: Claim for Attorney Fees
 - Form 14b: Claim for Physician Fees

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