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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

_____,

Respondent *Full name: first, middle, last*

Alleged to be Seriously Mentally Impaired

No._____

Chief Medical Officer's Periodic Report (Respondent Inpatient)

Iowa Code § 229.15(1)

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

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

3. In your opinion, Respondent's condition:

A. ☐ Has improved.

B. ☐ Remains unchanged.

C. ☐ Has deteriorated.

Explanation

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_____

_____

_____

☐ *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

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_____

☐ *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

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

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

If yes, state basis for answer

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☐ *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

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☐ *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

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

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

If yes, state basis for answer

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

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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

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_____

☐ *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

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_____

_____

_____

☐ *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*).

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

a. ☐ Is _____.

b. ☐ Cannot be determined at this time.

(2) Recommendation:
Check one

a. ☐ Respondent remain in this hospital.

b. ☐ Respondent be transferred to _____.

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

(3) Recommended further treatment:

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_____

_____

_____

☐ *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:

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_____

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_____

☐ *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:

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_____

_____

_____

☐ *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:

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_____

_____

_____

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

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13. Chief medical officer's signature

_____ _____
Printed name *Signature**

_____
Name of hospital or facility

_____
Mailing address

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

(____) _____
Phone number

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

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

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