



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.

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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.*