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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 _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Periodic Report (Respondent Outpatient)** 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 _____ ____, 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 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 treatment *Check one*

A. ☐ Respondent was tentatively discharged on _____ ____, 20____.
Month *Day* *Year*

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 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

Show Lines Hide Lines

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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*).

Recommended inpatient treatment:

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

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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:

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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 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. 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).