



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

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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).*