



Rule 12.36—Form 11: *Periodic Report (Alternative Facility Placement)*

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 (Alternative Facility Placement)

Alleged to be Seriously Mentally Impaired

Iowa Code § 229.15(4)

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 placement 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

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

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

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

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

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

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

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

Explanation

Check this box if you have attached additional pages.



If you checked 10(A), stop and sign below.

B. Respondent continues to be placed at this facility.

11. Proposed treatment and placement

In my 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

Check this box if you have attached additional pages.



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:

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:

Check this box if you have attached additional pages.

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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).

(1) Estimated further length of time Respondent will require treatment in this facility:
Check one

- a. Is _____.
- b. Cannot be determined at this time.

(2) Recommendation:
Check one

- a. Respondent remain in this facility.
- b. Respondent be transferred to _____.

(3) Recommended further treatment:

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:

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.*