**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.______________________

## Physician or Mental Health Professional's Report of Examination

Iowa Code § 229.10
Iowa Ct. R. 12.13

**1.** Date and time of examination: ________________ ____, 20___ at ____:____ ☐ a.m. ☐ p.m.
*Month Day Year Time*

**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 229.11? ☐ Yes ☐ No

**4.** Did a qualified mental health professional assist with this exam? ☐ Yes ☐ No

If yes, provide that person's name: ______________________________
*Mental health professional's name*

______________ ______________________ ______________, ______ ________
*Business name Address City State ZIP code*

*Attach the mental health professional's report, if written*

***Continued on next page***

**5.** In your judgment, is Respondent mentally ill? ☐ 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 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 judgment, 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.*

**8.** In your judgment, is Respondent likely to physically injure self or others if allowed to remain at liberty without treatment? ☐ 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.*

**9.** In your judgment, 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 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.*

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**10.** In your judgment, 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.*

**11.** Does Respondent have a prior history of noncompliance with treatment that has been a significant factor in the need for emergency hospitalization or 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.*

**12.** Can Respondent be evaluated on an outpatient basis? ☐ Yes ☐ No

*State basis for answer*

______________________________________________

______________________________________________

______________________________________________

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

**13.** 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

*State basis for answer*

______________________________________________

______________________________________________

______________________________________________

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

**14.** Is full-time hospitalization necessary for evaluation? ☐ Yes ☐ No

**15.** Does Respondent have a prior history of other physical or mental illness? ☐ Yes ☐ No

*If yes, specify*

______________________________________________

______________________________________________

______________________________________________

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

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**16.** 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.*

## 17. Physician or mental health professional's 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.*