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

**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.*

STOP *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.*

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:

_____

_____

_____

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

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.*



[Court Order August 17, 2022, effective November 1, 2022]