



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

No. \_\_\_\_\_

Respondent *Full name: first, middle, last*

**Periodic Report  
(Respondent Outpatient)**

**Alleged to be Seriously Mentally Impaired**

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*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*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*

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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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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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

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**13. Signature**

<i>Signature*</i>	<i>Printed name</i>	
<i>Title**</i>	<i>Name of facility</i>	
<i>Mailing address</i>		
<i>City</i>	<i>State</i>	<i>ZIP code</i>
( )		
<i>Phone number</i>		
<i>Email address</i>	<i>Additional email address, if applicable</i>	
Month	Day	20 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).*

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