



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.
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 229.10? 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 likely to 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.*