

IN THE IOWA DISTRICT COURT IN AND FOR XXX COUNTY

In the Matter of: <hr/> Alleged to be Seriously Mentally Impaired, Respondent.	Case # PERIODIC REPORT PURSUANT TO IOWA CODE SECTION 229.15(2)(4)
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MEDICAL OPINION:

1. In my judgment, respondent is currently mentally ill. Yes No

If YES, state diagnosis and supporting facts:

2. In my judgment, because of that mental illness the respondent currently lacks sufficient judgment to make responsible decision with respect to his/her hospitalization or treatment? Yes No

If YES, state supporting facts as to how their mental illness prevents them from doing so:

3. In my judgment, the respondent is treatable? Yes No

4. In my judgment, the respondent is currently likely to physically injure himself/herself or others, if allowed to remain at liberty without treatment.

Yes No

If the answer is YES, what **recent overt acts or threats** (either personally observed or a part of the history) did you rely upon in rendering your opinion (**when relying on history provide timeframe**):

5. In my judgment the respondent is currently likely to inflict serious emotional injury on family members or those unable to avoid contact with the respondent, if allowed to remain at liberty without treatment? Yes No

If the answer is YES, state supporting facts:

6. The respondent is currently incapable of satisfying his/her needs for nourishment, clothing, essential medical care or shelter so that it is likely that he/she will suffer physical injury, physical debilitation or death within the reasonably foreseeable future?

Yes No

If the answer is YES, state supporting facts:

7. The respondent is currently compliant with his/her treatment and appointments?

Yes No

TREATMENT RECOMMENDATIONS:

8. I find:

a. That the respondent does not, as of the date of the report require further involuntary treatment. Any continued treatment will be done on a voluntary basis.

b. That the respondent should continue with involuntary outpatient treatment.

Outpatient Provider: _____

c. That the respondent continues to be in need of full-time custody and care other than a hospital.

Alternate Placement: _____

Attending psychiatrist/physician or ARNP: _____

9. I believe the recommended course of treatment is the least restrictive, effective treatment for the respondent as demonstrated by:

10. I estimate that the further length of time the respondent will require involuntary outpatient or other involuntary appropriate treatment at this facility to be (not possible to determine) (_____days).

Signed: _____
Provider Name

M.D. D.O. A.R.N.P.
Circle Title

Printed Name: _____

Date: _____

Facility: _____

Respondent's current address: _____
