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KETAMINE TREATMENT CONSENT

Patient Name: _____ Date of Birth: _____

Please Initial Each Statement:

_____ Ketamine is an anesthetic agent. At subanesthetic doses (doses below the amount necessary for general anesthesia), ketamine can be useful in the treatment of depression, pain, and other conditions.

_____ Use of Ketamine for purposes other than anesthesia is considered off-label and investigational by the Food and Drug Administration, although it is an FDA-approved medication for anesthesia. Nevertheless, I wish to have Ketamine used for such off-label use and I am willing to accept the potential risks that my provider has discussed with me. I acknowledge that there may be other, unknown risks and that the long-term effects and risks of Ketamine in such off-label use are not known.

_____ Like all medical treatments, I understand that there is no guarantee ketamine therapy, or any treatment modality, will be successful.

_____ Potential side effects from ketamine include dizziness, blurred vision, bad dreams, perceptual disturbances, confusion, elevations in blood pressure and heart rate, euphoria, fatigue, irritability, and nausea. Infection, soreness, bruising or bleeding at injection site is possible. Rare side effects, expected only at higher doses than those prescribed by our office, include urinary pain and erectile dysfunction – if this occurs I will report it to the office immediately.

_____ I agree, I will NOT drive or participate in any hazardous activity during the acute effects of the drug. I agree I will not sign any legal documents for 24 hours after the treatment.

_____ There is a small risk of habituation and problematic use with ketamine. No addiction issues have arisen in the many studies investigating ketamine for use in depression, and no issues have arisen in the many decades that ketamine has been used for anesthesia. Nevertheless, the risk does exist and I am willing accept such risk.

_____ I have received the Ketamine Information Sheet provided by Integr8 Health and have been given the opportunity to ask any questions I may have had about the information contained in that Information Sheet.

_____ I understand that ketamine is a controlled substance (Schedule III) and I must not share my prescription with anyone, and that I must only take the medication as prescribed. I understand that I will be **required to have a follow up with my provider every 90 days** for continued therapy.

_____ I have been explained thoroughly about the use of Ketamine for my condition and I had the opportunity to ask all the relevant questions I felt necessary. I voluntarily request Dr. Dustin Sulak, DO and/or his team at Integr8 Health to prescribe and/or administer ketamine to treat my condition.

Patient Signature: _____ Date: _____