KETAMINE TREATMENT CONSENT

Date:____________ 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 is useful in the treatment of Major Depression and Chronic Pain Syndromes.

________ Use of Ketamine for the treatment of Major Depression is considered investigational by the Food and Drug Administration, although an FDA-approved medication for anesthesia.

________ According to the literature, Ketamine is efficient for Depression in about 70% of the cases and the effects typically last for about 2 weeks. Longer or shorter duration of action is possible. Like all medical treatments, I understand that there is no guarantee Ketamine infusion 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 or heart rate, euphoria, fatigue, and nausea. These side effects mostly disappear after the infusion is complete and ketamine infusion is well tolerated.

________ There is a small but not zero risk of habituation 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.

________ I have been explained thoroughly about the use of Ketamine for Major Depression or Chronic pain syndromes and I had the opportunity to ask all the relevant questions I felt necessary.

________ I voluntarily request Dr. Melissa Reed, MD and/or her team at Klarity Ketamine Wellness Clinic to administer Ketamine for the treatment of my condition.

________ I understand that I can revoke this consent at any time including during the infusion.

________ I understand that the duration of the infusion will be approximately one hour and I understand that it will be necessary for me to stay in the office for a while after the infusion ends, typically a few more hours. Also, I understand I must not drive for the rest of the day following the infusion.

Patient Signature:____________________________________ Date:____________________

Witness Signature:___________________________________ Date:______________________

Name (Printed):______________________________________