THE KETAMINE CLINIC
MENTAL HEALTH. MODERN CARE.

Ketamine Therapy Consent Form

Patient Name: ______________________________
Date of Birth: ______________________________
Date: ______________________________

Introduction

Ketamine is a medication primarily used for anesthesia, but recent research has shown its effectiveness in treating various mental health conditions, including depression, anxiety, PTSD, and chronic pain. It is administered under controlled conditions in our clinic by licensed professionals. Please read this form carefully and ask any questions before signing.

Purpose of Treatment

I understand that the purpose of receiving ketamine treatment is to help manage my condition(s) of:
( ) Depression
( ) Anxiety
( ) PTSD
( ) Chronic Pain
( ) Other: __________________________

Treatment Procedure

- I will receive ketamine through the following methods (circle as applicable):
  ( ) Intravenous (IV) Infusion
  ( ) Intramuscular (IM) Injection
  ( ) Nasal Spray
  ( ) Oral
- The typical dosage and frequency of my treatments will be discussed with me by my provider.
- I understand that the treatment may take place in a monitored and controlled environment, and the effects will be closely observed by licensed professionals.

Risks and Side Effects

I understand that ketamine therapy, like all treatments, carries certain risks, including but not limited to:

- Nausea, dizziness, or headache
- Increased heart rate or blood pressure
- Dissociation or feeling "disconnected" from reality
- Hallucinations or vivid dreams

- Anxiety or agitation
- Confusion or memory disturbances
- In rare cases, severe side effects may include heart arrhythmias, respiratory depression, or allergic reactions.

I understand that if I experience any severe side effects or complications, I will contact my treatment provider immediately.

Benefits

I understand that the potential benefits of ketamine therapy include:

- Reduction in symptoms of depression, anxiety, PTSD, and chronic pain
- Improvement in overall mood and well-being
- Potential long-lasting effects with continued therapy

However, I understand that the benefits may vary from person to person and that not all individuals will experience the same outcomes.

Alternative Treatments

I have been informed of alternative treatment options for my condition, which may include traditional medications, therapy, or other interventions. I have had the opportunity to discuss these alternatives with my provider and understand that I may choose them instead of ketamine therapy.

Contraindications

I affirm that I do not have the following conditions (please check all that apply):

- ( ) Severe heart disease or arrhythmia
- ( ) History of psychosis or schizophrenia
- ( ) History of substance abuse or addiction
- ( ) Severe liver or kidney problems
- ( ) Pregnancy or breastfeeding
- ( ) Other medical condition(s) ________________________________

If any of the above apply to me, I understand that ketamine treatment may not be appropriate, and alternative therapies will be discussed.

Consent to Treatment

By signing below, I acknowledge:

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- I have had the opportunity to ask questions regarding ketamine treatment.
- I have received adequate explanations about the procedure, risks, benefits, and alternatives.
- I understand that I have the right to withdraw my consent and discontinue treatment at any time without affecting my future medical care.
- I consent to the administration of ketamine and related medical interventions as part of my treatment plan.

Confidentiality

I understand that my treatment and all related medical information will be kept confidential, except as required by law or with my written consent for disclosure to other healthcare providers.

Acknowledgment

I acknowledge that I have read and fully understand the contents of this consent form. All of my questions have been answered to my satisfaction, and I voluntarily consent to ketamine treatment.

Patient Signature: ______________________________
Date: ______________________________

Provider Name: ______________________________
Provider Signature: ______________________________
Date: ______________________________