

Patient consent and disclaimer for ketamine treatment

I, the undersigned patient, have been fully informed and understand the nature and scope of the ketamine therapy offered by **The Ketamine Clinic**. I acknowledge that my participation in this treatment is voluntary and that I have had the opportunity to have all my questions answered to my satisfaction.

1. Acknowledgment of off-label use

I understand that while ketamine is an FDA-approved anesthetic, its use for treating psychiatric conditions (such as depression, anxiety, or PTSD) or chronic pain is considered "off-label". This means that the FDA has not specifically evaluated ketamine for safety or effectiveness for these conditions. I also understand that only esketamine nasal spray (Spravato®) is FDA-approved for treatment-resistant depression in specific clinical settings.

2. Potential risks and side effects

I have been informed of the potential risks and side effects associated with ketamine therapy, which may include, but are not limited to:

- **Common, temporary side effects:** Dizziness, blurred vision, nausea, vivid dreams, hallucinations, or an "out-of-body" or dissociative sensation.
- **Cardiovascular effects:** A temporary increase in heart rate and blood pressure.
- **Rare, but more severe risks:** Allergic reactions, irregular heartbeat (arrhythmia), or bladder irritation (cystitis) with frequent long-term use.
- **Psychological risks:** Heightened anxiety or panic attacks during the infusion.
- **Addiction potential:** I acknowledge that ketamine is a controlled substance (Schedule III) and that while the risk of addiction is low in a clinical setting with controlled dosing, recreational use carries a higher risk.

I understand that if my blood pressure gets too high or if I become agitated, 911 may be called and I may be sent to an emergency room for further treatment.

3. Benefits and limitations

I understand that ketamine therapy is not a guaranteed cure and that results can vary among individuals.

- **No guarantee of results:** No promises or assurances have been made regarding the outcome of my treatment.
- **Temporary effects:** The potential therapeutic effects of ketamine may not be permanent and may require follow-up "booster" infusions.
- **Augmentation, not replacement:** I understand that ketamine therapy is an adjunct treatment and does not replace comprehensive medical care, psychiatric care, or psychotherapy.

4. Precautions and patient responsibility

I agree to abide by the following safety precautions:

- **Fasting:** I will not eat or drink for at least 4-6 hours prior to my ketamine session, as instructed by the clinic.
- **Alcohol** – I will not drink alcohol 24 hours before or after my treatment with ketamine
- **Transportation:** I will not drive or operate hazardous machinery for at least 24 hours following my infusion. I will arrange for a responsible adult to drive me home.
- **Important decisions:** I will refrain from making any major business or personal decisions on the day of my treatment.
- **Medication disclosure:** I have fully disclosed all medications, including prescriptions, over-the-counter drugs, and supplements, that I am currently taking. I also understand that certain medications, like benzodiazepines, should be held prior to treatment, as advised by the clinic.
- **Reporting:** I will immediately notify clinic staff or seek emergency care if I experience severe side effects, extreme mood changes, or thoughts of self-harm.

5. Voluntary participation and right to withdraw

I understand that my consent to this treatment is voluntary and that I have the right to withdraw my consent and stop treatment at any time, without penalty. I also understand that the treating physician may terminate treatment at any time if they deem it medically necessary.

6. Assumption of risk



I acknowledge that I have been informed of the potential risks and accept them. I release **The Ketamine Clinic** and its staff from any liability arising from known risks or complications that are not due to negligence.

Patient and witness signatures

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Witness Name (Printed): _____

Witness Signature: _____

Date: _____