Ketamine Assisted Therapy

Psychiatric Solutions

THE ART AND SCIENCE OF HEALING
AND REWIRING THE BRAIN

Consent to Treat With Ketamine

I, _____, agree to observe and understand the following risks and protocol of Ketamine Treatment.

Ketamine may increase blood pressure during treatment and although the likelihood is low, following are some of the common adverse effects of Ketamine: drowsiness, dizziness, light headedness, nausea, eye tracking, blurry or double vision, nausea, vomiting, and in most rare circumstances urinary retention.

I observe and understand that I **should refrain** from taking any **benzodiazepines or alcohol 24 hours within treatment**, and if I am currently taking any psychostimulants, I will refrain from taking any of these medication the day of the treatment. These medications can interfere with treatment.

I understand that eating directly before and or after my appointment may cause nausea, and some cases vomiting. To prevent this, I will eat no sooner than 2 hours before my scheduled apt, and wait 2 hours post appointment.

I understand that due to the risk of increased blood pressure, my blood pressure will be monitored by being taken before, during, and after the treatment.

I observe, understand, and agree to **not** driving home after my appointment and have arranged for someone else to drive me after my ketamine treatment. I have read and agree to follow the protocol when participating in Ketamine Treatment.

In addition, By signing this form: I release Carrie Sclar Stevens PA-C, Emily Risner, and Ketamine therapy solutions from any liability should an adverse event occur if I do not follow these recommendations.

Patient Name_____ Date_____

Patient Signature_____

Provider Name_____ Date_____

Provider Signature_____

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