



## Consent to Treatment with Ketamine Repeat Treatments

Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Procedure: administration of ketamine

- Sublingual
- Nasal
- Intramuscular
- Intravenous

### Provider's Statement

In my opinion, there is no reason to doubt this patient's capacity to make this decision.

I have explained the treatment to the patient. In particular, I have described the intended benefits, including:

- reduction in feelings of depression, anxiety, and obsessive-compulsive symptoms
- reduced suicidal thoughts
- improved function.

I have also outlined significant, unavoidable, or frequently occurring risks, including short-term effects of dry mouth, nausea, dizziness, light-headedness, feelings of unreality, and rarely, hallucinations.

Long-term effects are unclear, but cognitive difficulties, bladder problems, and elevated liver enzymes have been reported in some with regular high-dose usage. Less than 1% of patients have problems with misuse of ketamine.

I have also discussed:

- that this currently is an off-label use of ketamine
- what the procedure involves, including financial costs
- any particular concerns of the patient
- the risks and benefits of alternative treatments, including no treatment.

I have provided the ketamine patient information leaflet.

\_\_\_\_\_  
Signed  
Lisa Blackwelder FNP-C, PMHNP-BC

\_\_\_\_\_  
Date Name

### Statement and Signature of Patient

You will be offered a copy of this form. You have the right to change your mind at any time, including after you have signed this form.

- I have read the Patient Information Leaflet.
- I understand the information that I have been given about the treatment described on this form.
- I agree to the course of treatment described on this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date