Bridger Psychiatric Services

Consent for Ketamine Treatment

Patient Name: _____ Date: _____

I consent to the treatment of depression using an experimental Ketamine therapy. I understand that this treatment has not yet been approved by the FDA. The dose I am to receive is low, which decreases the likelihood of experiencing side effects. However, I understand that side effects may occur.

I acknowledge that potential side effects to this treatment include depersonalization, derealization, worsening of depressed mood should the treatment not be effective, hallucinations (in high doses), irritability, hypomania, delirium, tachycardia, nystagmus, double vision, and high blood pressure.

I understand that should I experience any of the above side effects or notice that I am feeling unwell or abnormal in any way I will notify Bridger Psychiatric Services immediately. I understand that I will be offered any required treatments through Bridger Psychiatric Services or referred to an appropriate provider.

I agree to abstain from using illicit substances while undergoing Ketamine therapy, and understand that I may be required to submit to a drug screen by either buccal swab or urinalysis at any time.

I will notify my provider of any and all medications that I am taking, both prescribed and over the counter, throughout the course of my treatment. I will take my medications only as prescribed and will contact my provider prior to any changes. I understand that failure to do so may result in termination.

Due to the nature of the medication early fills and refills for lost or stolen medications are not permitted.

By Signing this consent form, I understand that the nature of the treatment I am to receive and acknowledge the potential side effects.

_____	_____	_____
Patient/Guardian Name	Patient/Guardian Signature	Date

_____

Relationship to Patient