Patient Information

Patient Name:________________________________ DOB:____________________

Driver's License:______________________________ SSN:____________________

Home Phone:__________________________________ Sex:____________________

Address:____

City:_____________________________State:_________Zip:__________________

Cell:_______________________ Email:_____________________________________

Emergency Contact Information

Emergency Contact:____

Home Phone:_________________________ Cell:___________________________

Address:____

Relationship:_________________________ Work:___________________________

Emergency Contact:____

Home Phone:_________________________ Cell:___________________________

Address:____

Relationship:_________________________ Work:___________________________

Medical History

Current Medications:____

Allergies:____

Medical Doctor:____

Address:____

Phone Number:____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ x-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment is due at time of service.

____ ___________________________

Patient Signature Date

Patient Instructions

Pre-Treatment:

1. No solid food or milk products for four (4) hours before your treatment time.

2. Food and beverages are not permitted during the infusion.

3. Please turn off all cell phones during treatment.

4. You may bring your own pillow and blanket for comfort during the infusion.

5. No reading or watching movies during treatment.

6. No narcotics on the day of treatment. Take your normal medications the morning of your treatment with a sip of water.

7. Please try to maintain a calm, quiet demeanor throughout the infusion in effort to remain relaxed and comfortable.

Post-Treatment:

1. No driving or operating heavy equipment for 24 hours after a treatment.

2. No alcohol consumption within 24 hours after completing the infusion.

3. Resume regular diet as tolerated. On rare occasions, some patients will experience nausea

4. Resume normal afternoon or evening medications.

5. Go to the emergency room if you experience chest pain, hives, shortness of breath, increasing weakness or swelling of your IV site with redness. It is normal to feel fatigue the day of treatment.

Complete Ketamine
SOLUTIONS

Permission to Use Ketamine as a Treatment for Depression

Ketamine is a drug that calms and relaxes the body. It is approved by the FDA for use in anesthesia and as a pain reliever during medical procedures. It generally does not impact your breathing. Ketamine's use for treatment of depression or other mental illnesses is off-label and has not been approved by the FDA.

Why Is Ketamine Being Recommended for Me?
Research has shown that ketamine may be helpful in the treatment of depression. When administered intravenously over a period of about 60 minutes (called an infusion), ketamine may help depression improve rather quickly, but it may last only a few days. A series of infusions is used so that the improvement lasts much longer. While the goal is improvement of depression, results cannot be guaranteed.

What Will Be Done?
I will be receiving ketamine by IV Infusion. This means an IV will be inserted into a vein of my hand or arm and fluid will be dripped into the vein over roughly 60 minutes. This fluid will contain a ketamine dose of 0.5 mg/ kg of my body weight. (By comparison, when ketamine is used for anesthesia, the dose is often much higher and is given via a rapid IV push, as opposed to a slow infusion over 60 minutes). After the treatment, I will need a bit of time to recover and may take some sips of fluid if I feel like doing so. I understand that I will be scheduled to receive 6 treatments over about two weeks as a treatment episode. Additional maintenance treatments may or may not be suggested, occurring about once a month or less frequently depending on how I respond to the infusions.

What Safety Precautions Must I Take?

- I may not eat or drink for 4 hours before each of the infusions.
- I may NOT drive a car, operate hazardous equipment, or engage in hazardous activities for 24 hours after each treatment, as reflexes may be slow or impaired. Another adult will need to drive me home.
- I should refrain from alcohol and other narcotic substances for 24 hours prior to and after treatment infusions.
- I must tell the clinic about all medications I am taking, especially narcotic pain relievers or barbiturates.
- In order to qualify to receive ketamine therapy, I will require medical clearance and must share with my ketamine provider the contact information for the doctor or doctors who are treating my depression or anxiety or other psychiatric symptoms.
- If I experience a side effect while I am at home, I should contact the Complete Ketamine Solutions, my primary care doctor, call 911 or go to my local emergency room.

What Are the Side Effects of Ketamine?
When Ketamine is used as an anesthetic agent the following are listed as side effects:

- fast, irregular or low heart beats
- increased or decreased blood pressure
- dreams that may seem real
- confusion
- irritation or excitement when waking up
- floating sensation ("out-of-body")
- breathing problems
- twitching, muscle jerks, and muscle tension
- increased saliva or thirst
- lack of appetite
- headaches
- metallic taste
- constipation
- blurry or double vision
- nausea or vomiting
- risk of drug addiction or dependence

Rare side effects of ketamine are:

- allergic reactions
- pain at site of injection
- increase in pressure inside the eye
- ulcerations and inflammation in the bladder
- Pancreatitis
- hallucinations
- euphoria
- involuntary eye movements
- low mood or suicidal thoughts

Side effects of receiving an IV are:

- mild discomfort at the site of placement
- bruising
- bleeding
- dizziness
- fainting
- infection

Important Notices and Agreements:

- KETAMINE INFUSION THERAPY IS NOT A COMPREHENSIVE TREATMENT FOR DEPRESSION, ANXIETY OR ANY PSYCHIATRIC SYMPTOMS.
  Your ketamine infusions are meant to augment (add on to, not be used in place of) comprehensive psychiatric treatment. We advise you to be (and I agree to be) under the care of a qualified mental health professional (or an internal medicine or family physician with experience and skill in treating psychiatric illnesses) while receiving ketamine infusions, and for the duration of your psychiatric symptoms.

- SPECIAL NOTE ON SUICIDAL IDEATION
  Psychiatric illnesses (especially, depression) carry the risk of suicidal ideation (thoughts of ending one's life). Any such thoughts you may have now, at any time during the weeks of your ketamine infusions, or at any point in the future, which cannot immediately be addressed by visiting with a mental health professional should prompt you to seek emergency care at an ER or to call 911.

- Ketamine use during pregnancy is not generally recommended.

- Caution is highly recommended with ketamine use in patients under the age of 16.

My Consent for Ketamine Treatment is Voluntary:
My request for Complete Ketamine Solutions to conduct ketamine infusion treatments as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse ketamine treatments and that my regular treatments for depression would continue. Any money I have deposited that has not been subject to fees by Complete Ketamine Solutions will be refunded to me if I choose not to proceed. I have been advised that I can seek a second opinion from another doctor before agreeing to have ketamine treatment and am choosing to proceed at this time with or without this second opinion. I also acknowledge and agree that ketamine infusions for the treatment of depression is not FDA approved at this time and is still considered experimental and that the results of my treatment with ketamine may be used to show the efficacy of ketamine treatment in depression but my personal health information would not be shared with outside parties without expressed written consent.

Complete Ketamine Solutions Infusion Clinic, in the hopes to mitigate the possible abuse of Ketamine outside of their facility, participates in random patient drug testing. I hereby agree to participate in random urine drug screening prior to any of my Ketamine infusions. I understand that if I am randomly chosen to perform a urine drug screen, and I refuse, I must discuss with Complete Ketamine Solutions Medical Director per their Policies and Procedures before I am allowed to proceed with treatment.

Statement of Person Giving Informed Consent

- I have read this consent form and understand the information contained in it.
- I have had the opportunity to ask questions about this procedure and consent and wish for Complete Ketamine Solutions and its staff to administer ketamine infusion treatment.

Signature of Patient or legally responsible party ______ Relationship to Patient ______ Date

______ Signature of Witness ______ Date

Patient/Witness Discharge Release

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- involuntary eye movements
- low mood or suicidal thoughts

Side effects of receiving an IV are:

- mild discomfort at the site of placement
- bruising
- bleeding
- dizziness
- fainting
- infection

Important Notices and Agreements:

- KETAMINE INFUSION THERAPY IS NOT A COMPREHENSIVE TREATMENT FOR CHRONIC PAIN, OR OTHER SYMPTOMS RELATED TO PAIN
  Your ketamine infusions are meant to augment (add on to, not be used in place of) comprehensive pain treatment. We advise you to be (and I agree to be) under the care of a qualified health professional (an internal medicine or family physician with experience and skill in treating chronic pain) while receiving ketamine infusions, and for the duration of your pain symptoms. Unless otherwise agreed to, Complete Ketamine Solutions will not be the provider of these services. Follow up medications may be suggested but these will be the responsibility of my treating physician.
- SPECIAL NOTE ON SUICIDAL IDEATION
  Chronic illnesses such as pain and depression carry the risk of suicidal ideation (thoughts of ending one's life). Any such thoughts you may have now, at any time during the weeks of your ketamine infusions, or at any point in the future, which cannot immediately be addressed by visiting with a mental health professional should prompt you to seek emergency care at an ER or to call 911.
- Ketamine use during pregnancy is not generally recommended
- The safety of ketamine use in patients under the age of 16 has not been determined

______________________________ ________________________
Signature of Patient Date

______________________________ ________________________
Signature of Witness Date

Time and Date of Departure from Clinic: ______________________________

Note: Due to Ketamine's possible side effects, it is discouraged that the patient operates a vehicle or heavy machinery within 24 hours of leaving the clinic.

The medical/psychiatric provider treating my symptoms of depression, anxiety, PTSD, and/or chronic pain is:

Name

Phone FAX

Address

Email

RELEASE OF MEDICAL INFORMATION

I herby authorize my ketamine provider to disclose my medical records, including any history of substance use or abuse, to the individual listed above, or appropriate personnel in his or her office. I further authorize the individual listed above to disclose my medical records, including any history of substance use or abuse, to my ketamine provider, or appropriate personnel in his or her office.
I also authorize my ketamine provider to discuss my care and share information for the purposed of monitoring, biling, quality control and other business purposes with Complete Ketamine Solutions who has agreed to HIPAA levels of security about my personal information.

Signature of Patient or legally responsible party Date

IN THE EVENT OF AN EMERGENCY

My Emergency Contact Is:

Name

Phone Fax

Address

Relationship

I herby authorize my ketamine provider to disclose my medical condition to the above person in the event of concern about my post procedure recovery or any emergency situation so that this person may assist me as needed.

Signature of Patient or legally responsible party Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:____ DATE:__________________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult _________
Very difficult _____________
Extremely difficult _________

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		
6) Suicide Behavior Question: ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***<u>How long ago did you do any of these?</u>*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Hamilton Depression Rating Scale (HAM-D)

- Depressed Mood (Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
  0=Absent
  1=Sadness
  2=Occasional Weeping
  3=Frequent Weeping
  4=Extreme Symptoms

- Feelings Of Guilt
  0=Absent
  1=Self-reproach, feels he/she has let people down
  2=Ideas of guilt
  3=Present illness is a punishment; delusions of guilt
  4=Hallucinations of guilt

- Suicide
  0=Absent
  1=Feels life is not worth living
  2=Wishes he/she was dead
  3=Suicidal ideas or gestures
  4=Attempts at suicide

- Insomnia Initial (Difficulty in falling sleep)
  0=Absent
  1=Occasional
  2=Frequent

- Insomnia Middle (Complains of being restless and distrubed during the night Waking during the night.)
  0=Absent
  1=Occasional
  2=Frequent

- Insomnia Delayed (Waking in early hours of the morning and unable to fall asleep)
  0=Absent
  1=Occasional
  2=Frequent

- Work And Interests
  0=No difficulty
  1=Feelings of incapacity, listlessness, indecision and vacillation
  2=Loss of interest in hobbies, decreased social activities
  3=Productivity decreased
  4=Unable to work. Stopped working because of present illness only

- Retardation (Slowness of thought, speech, and activity; apathy; stupor)
  0=Absent
  1=Slight retardation
  2=Obvious retardation
  3=Difficult
  4=Complete Stupor

- Agitation (Restlessness associated with anxiety)
  0=Absent
  1=Occasional
  2=Frequent

- Anxiety (Psychic)
  0=No difficulty
  1=Tension and irritability
  2=Worrying about minor matters
  3=Apprehensive attitude
  4=Fears

- ❑ Anxiety (Gastrointestinal, ingestion, cardiovascular, palpitation, headaches, respiratory, genito-urinary)
  0=Absent
  1=Mild
  2=Moderate
  3=Severe
  4=Incapacitating

- ❑ Gastrointestinal (Loss of appetite, heavy feeling in abdomen, constipation)
  0=Absent
  1=Mild
  2=Severe

- ❑ Somatic Symptoms- General (Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
  0=Absent
  1=Mild
  2=Severe

- ❑ General Symptoms (Loss of libido, menstrual distrubances)
  0=Absent
  1=Mild
  2=Severe

- ❑ Hypochondriasis (Obsession with the idea of having a serious but undiagnosed medical condition)
  0=Not present
  1=Self-absorption
  2=Preoccupation with Health
  3=Querulous attitude
  4=Delusions

- ❑ Weight Loss
  0=No weight loss
  1=Slight
  2=Obvious or severe

- ❑ Diurnal Variation (Depression symptoms worse in morning or evening)
  0=No variation
  1=Mild variation__am__pm
  2=Severe variation__am__pm

- ❑ Depersonalization and Derealization (Feelings of unreality or nihilistic ideas)
  0=Absent
  1=Mild
  2=Moderate
  3=Severe
  4=Incapacitating

- ❑ Paranoid Symptoms (Not with a depressive quality)
  0=None
  1=Suspicious
  2=Ideas of reference
  3=Delusions of reference and persecution
  4=Hallucinations

- ❑ Obsessional Symptoms (Obsessive thoughts and compulsions)
  0=Absent
  1=Mild
  2=Severe