Complete Ketamine
SOLUTIONS

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

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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.

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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

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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

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Patient/Witness Discharge Release

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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 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.

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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

Chronic Pain Assessment Questionnaire

Pain is a patient-specific experience that requires ongoing assessment and evaluation, both by patients and their providers. This questionnaire will help assess the two parts of chronic pain that often change over time, persistent baseline and breakthrough pain. Please take a moment to complete this questionnaire.

Patient Information

❑ First visit ❑ Follow-up visit

Age ❑ 20-29 ❑ 30-39 ❑ 40-49 ❑ 50-59 ❑ 60-69 ❑ 70+

Height Weight

Sex ❑ Male ❑ Female

Race ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other

Pain Diagnosis

Assessment of Persistent Baseline Pain

1 During the past week, have you had any pain or would you have had pain if not for the treatment you are receiving?

- ❑ If **Yes**, please proceed to the next question.
- ❑ If **No**, your pain profile may not include persistent baseline pain; please return this form to your physician.

2 Is this pain present continuously (most of the day) on most days or would the pain persist if not for the treatment you are receiving?

- ❑ If **Yes**, please proceed to the next question. This is known as persistent baseline pain.
- ❑ If **No**, your pain profile may not include persistent baseline pain; please return this form to your physician.

3 During the past week, on average, how would you rate your baseline pain on a scale of 0 to 10? (Refer to ***Figure 1A***)

- ❑ If **Severe**, your baseline pain may be uncontrolled; please return this form to your physician who may adjust your baseline treatment as needed.
- ❑ If **Mild** or **Moderate**, your baseline pain is controlled. Please proceed to the next question.

4 Assess the nature of your baseline pain

- Where do you feel this pain? (Refer to ***Figure 1B***)
- What does the pain feel like? (Refer to ***Figure 1C***)
- How long have you experienced this pain? **(in weeks)**
- Does anything that you do reduce your pain? ❑ Yes ❑ No
  If **Yes**, please describe what reduces your pain:
- Does anything that you do make your pain worse? ❑ Yes ❑ No
  If **Yes**, please describe what makes your pain worse:

5 Are you taking opioid medications **daily**?

- ❑ If **Yes**, which opioid are you taking?

  How often are you taking it?

  Please proceed to the next question.
- ❑ If **No**, please proceed to the next question.

6 **Evaluate for breakthrough pain** *(see reverse)*

FIGURE **1A** Please rate your **baseline pain** by circling the one number that best describes your pain on the average during the past week.

0-10 Numeric Pain Intensity Scale

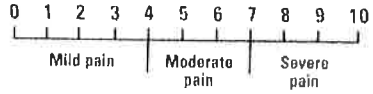

FIGURE **1B** Where do you feel this pain?

(In the diagram below shade in the areas where you experience this pain)

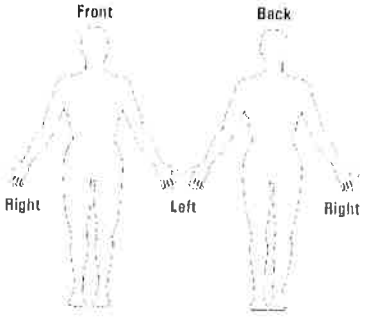

FIGURE **1C** What does the pain feel like?

(Check all that apply)

❑ Aching	❑ Hurting	❑ Shooting
❑ Agonizing	❑ Intense	❑ Shooting
❑ Annoying	❑ Itchy	❑ Sickening
❑ Beating	❑ Miserable	❑ Sore
❑ Burning	❑ Nauseating	❑ Spreading
❑ Cold	❑ Numb	❑ Squeezing
❑ Cramping	❑ Piercing	❑ Stabbing
❑ Crushing	❑ Pinching	❑ Stinging
❑ Cutting	❑ Pounding	❑ Suffocating
❑ Dreadful	❑ Pressure	❑ Tearing
❑ Dull	❑ Pricking	❑ Throbbing
❑ Exhausting	❑ Pulling	❑ Tight
❑ Flashing	❑ Pulsing	❑ Tingling
❑ Flickering	❑ Radiating	❑ Troublesome
❑ Freezing	❑ Scalding	❑ Tugging
❑ Hot	❑ Sharp	❑ Unbearable

Assessment of Breakthrough Pain

1 Do you have periods during the day when you have temporary episodes of uncontrolled pain (also known as breakthrough pain)?

- ❑ If **Yes**, how often? _____
- What time of day do these episodes occur?
- ❑ If **No**, please return this form to your physician.

2 How long does it take from the time you first notice the pain until it is at its worst?

- How long do the episodes last?
- How long does it usually take from the time you take medicine until the pain goes away?

3 How would you rate your breakthrough pain at its worst on a scale of 0 to 10? (Refer to ***Figure 2A***)

4 Where do you feel this pain? (Refer to ***Figure 2B***)

5 What does the pain feel like? (Refer to ***Figure 2C***)

6 Do you know what causes these breakthrough pain episodes? ❑ Yes ❑ No

- Are the episodes associated with certain activities (for example, gardening, walking)? ❑ Yes ❑ No
  If **Yes**, what are these activities?
- Does the onset occur with certain bodily functions (for example, coughing, sneezing)? ❑ Yes ❑ No
  If **Yes**, what are these bodily functions?
- Does the onset usually occur right before a scheduled dose of your pain medication? ❑ Yes ❑ No

7 Are these episodes of breakthrough pain the same type of pain as your usual pain? ❑ Yes ❑ No

If **No**, how do they differ?

8 Do the episodes of breakthrough pain affect your ability to handle daily responsibilities at home or work? ❑ Yes ❑ No

If yes, how often?

9 To what extent does avoiding activities due to fear of an episode of breakthrough pain compromise your quality of life?

❑ A little ❑ A fair amount ❑ A lot ❑ An extreme amount

10 Does anything help lessen the severity of these episodes of breakthrough pain? ❑ Yes ❑ No

- What helps?
- What doesn't help?

11 Do you take any breakthrough pain medication(s)? ❑ Yes ❑ No

If yes, complete questions 12 and 13. If no, please return this form to your physician.

12 In the past 24 hours, how long has it taken for your breakthrough pain medication to begin to take effect? _____ minutes

13 In the past 24 hours, how satisfied or dissatisfied have you been with how fast your breakthrough pain medication began to reduce your breakthrough pain?

❑ Very satisfied ❑ Satisfied ❑ Neutral ❑ Dissatisfied ❑ Very dissatisfied

Additional Patient Information

Marital Status

Occupation

FIGURE **2A** Please rate your **breakthrough pain** by circling the one number that best describes your pain on the average during the past week.

0-10 Numeric Pain Intensity Scale

FIGURE **2B** Where do you feel this pain?

(In the diagram below shade in the areas where you experience this pain)

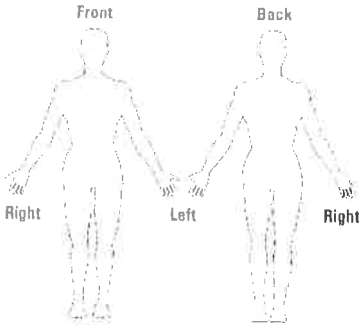

FIGURE **2C** What does the pain feel like?

(Check all that apply)

❑ Aching	❑ Hurting	❑ Shooting
❑ Agonizing	❑ Intense	❑ Shooting
❑ Annoying	❑ Itchy	❑ Sickening
❑ Beating	❑ Miserable	❑ Sore
❑ Burning	❑ Nauseating	❑ Spreading
❑ Cold	❑ Numb	❑ Squeezing
❑ Cramping	❑ Piercing	❑ Stabbing
❑ Crushing	❑ Pinching	❑ Stinging
❑ Cutting	❑ Pounding	❑ Suffocating
❑ Dreadful	❑ Pressure	❑ Tearing
❑ Dull	❑ Pricking	❑ Throbbing
❑ Exhausting	❑ Pulling	❑ Tight
❑ Flashing	❑ Pulsing	❑ Tingling
❑ Flickering	❑ Radiating	❑ Troublesome
❑ Freezing	❑ Scalding	❑ Tugging
❑ Hot	❑ Sharp	❑ Unbearable

Adapted from Portenoy RK, et al. *J Pain.* 2006;7:583-595; Hagen NA, et al. *J Pain Symptom Manage.* 2005;30:138-152; and the clinical practice of Michael J. Brennan, MD