Ketamine Intake Form

Name_____ Date of Birth_____

Address_____

Cell Phone: _____

Email:_____

I consent to the email address being used for appointment reminders as well as added to the Priority You email newsletter, where I will get information on specials and promotions.

How did you hear about us? _____

Person to contact in case of an emergency _____Phone _____

I request that medical information, test results, or messages:
(INITIAL below all that apply)
_____ be given only to me directly in person or over the phone
_____ be left on my home/cell answering machine/voice mail
_____ be left with a member of my household. Name_____
_____ be mailed to my mailing address listed above
_____* be emailed to me at _____

* I understand that email is not secure and may be intercepted by unauthorized people and possibly made available on the internet. Understanding this possibility and that you have advised me that you would prefer to send my confidential information by mail, I still request that you email me the confidential information to the above email address.

I consent to medical treatment. I agree to pay all charges for myself, and for members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

_____ _____

Signature Patient/ Parent/Guardian Date

Medical History

Previous or current primary care physician (PCP): _____

Date of last physical examination or visit to PCP: _____

Past/ Current Medical Conditions and Surgeries:

_____

_____

_____

Medication **ALLERGIES**: _____

Current Medications (please include dosages):

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Over-the-counter medications: _____

Herbal products, supplements, vitamins: _____

_____

Current Substance Use History:

Alcohol: Yes/ No How many drinks per day_____ When was your last drink? _____

Tobacco: Yes/ No How many per day_____

Any other recreational use of medications? Yes/No

If yes, please let us know what medication you are using and when was the last dose?

_____

Do you have a medical cannabis card? Yes/No

Please **mark** any of the following psychedelic drugs that you have tried in the past:

✖	Drug	Date last used	✖	Drug	Date last used
	Psilocybin (Mushrooms)			DMT	
	LSD (Acid)			Ayahuasca	
	MDMA (Ecstasy)			Ketamine	
	Opiates			Cocaine	
	Marijuana			Methamphetamines (Adderall, etc)	
	Heroin			Ketamine	
	Mescaline (Peyote)			Other: _____	

Reason for seeking Ketamine Treatment (select all that apply):

	Depression		Thoughts of Suicide
	Anxiety		Any past suicide attempts? Y/N When?_____
	Post Traumatic Stress Disorder (PTSD)		Addiction (Alcohol, Opiates, etc)
	Cognition (Brain) Enhancement		Traumatic Brain Inquiry (TBI)
	Chronic Pain		OCD (Obsessive Compulsive Disorder)
	Neurodegenerative Disease (Parkinson's, Alzheimer's, Stroke)		Other:

Personal & Lifestyle

Do you ever get motion sickness, car sick, or intolerant of rollercoaster type rides? Yes/ No

If yes, what triggers the motion sickness (ie car ride, roller coasters, etc)_____

Last episode of motion sickness:_____

Have you ever had an adverse reaction to anesthesia? Yes/ No If so, explain: _____

_____

Marital Status: Single/ Married/ Divorced/ Separated/ Partner. Occupation: _____{{__

Children? Yes/ No If so, ages: _____

History of abuse/ trauma/ assault? Yes/ No

If so, please explain: _____

Subjective Symptom Assessment

Please use the severity scale (below) to assign a score to each of these questions:

Symptoms	Score	Symptoms	Score
How satisfied with you with your **body**?		How would you rate your overall **mood**?	
How satisfied are you with your **weight**?		How would you rate your response to **stress?**	
How satisfied are you with your **sleep quality**?		How would you rate your ability to **manage stress?**	
How satisfied are you with your current **life**? (current day to day activities)		How do you feel you control **Anxiety?** **1= Severe; 5= Mild**	
How satisfied are you with your overall **health**?		Rate your level of feeling **depressed** **1= Severe; 5= Mild**	
How satisfied are you with your **exercise regimen**?		How would you rate your **job satisfaction?**	
How satisfied are you with your **energy level**?		Are you satisfied with **OTHERS perception** of you?	
How satisfied are you with your **libido**?		How satisfied are you with completing **tasks**?	
How satisfied are you with your **sexual performance**?		How satisfied are you with your **memory**?	
How satisfied are you with your **self-confidence**?		How satisfied are you with your **future plan**?	
Total Column 1:		**Total Column 2:**	
Total Score:			

Severity Scale	Score
Poor/ None	1
Could be better	2
Average	3
Content	4
Excellent/Very Happy	5

Score Results	Score Ranges (20- 100)
Severe	20- 36
Poor	37- 53
Average	54 -70
Good	71- 86
Excellent	87-100

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can gain access to this information. Please review this notice carefully.

Allowed Uses and Disclosures of Your Medical Information:

- Treatment – ie: ordering diagnostic tests or consultations
- Payment – ie: submitting bills to your insurance company
- Health Care Operations – ie: quality assurance and eligibility verification

We may also use your medical information for emergency treatment when we attempt to obtain consent and are unable to do so, and consent for treatment is implied under the circumstances.

You Have a Right to:

- Request restriction on certain uses and disclosures, however, we are not required to agree to any requested restriction
- Receive confidential communications from us, upon written request
- Inspect and request copies of your medical information, upon written request
- Request to amend incorrect or incomplete medical information, upon written request
- Receive an accounting of any disclosures made, upon written request

We are Responsible for:

- Maintaining the privacy of your medical information
- Abiding by the terms of this notice
- Providing written notice of any change to this notice

Authorizations: Upon your written authorization (verbal or implied in the event of an emergency), we may disclose your medical information to a requesting entity, such as another provider, relative, or an attorney. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

Patient Contact: We may contact you by telephone, SMS text, mail, or e-mail to provide such information as appointment reminders, treatment information or any other necessary communications.

Complaints: You may complain to us or to the Department of Health and Human Services if you believe that your privacy has been violated. If you wish to complain to us, please provide the Office Manager with written notice if you believe your privacy has been violated. All notices received will be investigated and reviewed by a Compliance Officer. You will receive a response to any notice within two weeks. To Obtain Information: Contact our Office Manager at 727-230-1438

I have received and reviewed a copy of the "Notice of Privacy Practices" Statement from Priority You

_____ _____

Signature Date

INFORMED CONSENT FOR KETAMINE INFUSION

Before you decide to take part in this procedure, it is important for you to know why it is being done and what it will involve. This includes any potential risks to you, as well as any potential benefits you might receive. Read the information below closely and discuss it with family and friends if you wish. Ask one of the clinical staff if there is anything that is not clear or if you would like more details. Take your time to decide. If you do decide to take part, your signature on this consent form will show that you received all of the information below, and that you were able to discuss any questions and concerns you had with a member of the staff. Depression, anxiety, PTSD, and/or chronic pain can be a severe, recurring, disabling, and life threatening condition. Current medical treatments including but not limited to are only marginally effective. You have chosen this procedure because other treatments have not been successful. In some studies, ketamine has been shown to provide rapid-acting antidepressant effects from a single infusion. Ketamine is widely used in emergency departments and operating rooms for the purposes of surgical sedation. **Ketamine has not been approved by the Food and Drug Administration (FDA) to treat depression. This is not a research study but is rather a clinical procedure. This procedure is not being monitored by the Institutional Review Board (IRB) or FDA.**

A. Procedures

1. You will be taken to the treatment room in order to receive the medication infusion

2. An intravenous line (IV) will be started in your arm so that you can receive the medication. Your heart rate and blood pressure will be monitored periodically throughout the infusion.

3. Under the supervision of a physician, you will receive ketamine through a vein in your arm over the course of approximately 40-60 minutes. The dose you receive will be based on your body weight. Most commonly patients receive between 0.5 mg to 1.0 mg of ketamine per kilogram of body weight.

4. After receiving the drug, you may be asked to rate the severity of your depression or fill out a subjective symptom assessment. You may also be asked to write a detailed account of your experience later that evening. Patients that are willing, may be asked to write a review or testimonial about their Ketamine Therapy.

5. You will be monitored and then released to go home when stable. You cannot drive home after the procedure unless you have waited a minimum of 4 hours. We therefore require you to be picked up by someone or utilize uber/ taxi service.

B. Risks/Discomforts

Any procedure has possible risks and discomforts. The procedure may cause all, some or none of the risks or side effects listed. Rare, unknown, or unforeseeable (unexpected) risks also may occur.

1. Risk of ketamine

Side effects normally depend on the dose and how quickly the injection is given. The dose being used is lower than the approved anesthetic doses and will be given slowly over approximately 60 minutes. These side effects often go away on their own. No lingering effects have been reported. Side effects normally depend on the dose

Uncommon side effects (> 0.1% and < 1%: between 1 out of 1,000 and 10 out of 1,000)

- Jerky arm movements, which resemble a seizure (as a result of increased muscle tension) and cross-eye
- Double vision
- Rash
- Pain and redness in the site of injection
- Increased pressure in the eye

Rare side effects (greater than 0.01% and less than 0.1%: between 1 out of 10,000 and 10 out of 10,000)

- Allergic reaction
- Irregular heart rate or slow-down of heart rate
- Low blood pressure
- Arrhythmia

Other risks: Misuse (drug abuse) of ketamine has been reported in the past. Reports have indicated that ketamine can cause various symptoms, including but not limited to flashbacks, hallucinations, feelings of unhappiness, restlessness, anxiety, insomnia, or disorientation. Individuals with a history of drug misuse or dependence can develop a dependency on ketamine.

As ketamine is used for sedation in surgery, the doses used in this study may cause sleepiness and may put you to sleep. There is a potential risk of dosing error or unknown drug interaction that may cause significant sedation and may require medical intervention including intubation (putting in a breathing tube).

As a result of ketamine you may experience the above reactions and require continued hospitalization for management of your mental and physical health. This medication may not help or even worsen your depression. Experiencing these symptoms may cause you to need medical hospitalization.

Risk of venipuncture: The risks of IV catheter insertion include temporary discomfort from the needle stick, bruising, and infection. Fainting could also occur.

Risk of other medications:

If you are currently taking certain medications on a daily basis within 24 hours prior to and / or after receiving ketamine, you will not be able to take these medication(s) while receiving a ketamine infusion without clearance or approval of the physicians involved in administering ketamine. This is due to concerns for potential increased sedation and / or trouble breathing.

Examples include:

- Sedatives (e.g., clonazepam, lorazepam, alprazolam)
- Antibiotics (e.g., azithromycin, clarithromycin)
- Antifungal agents (e.g., ketoconazole)
- Tramadol

B. Benefits:

Ketamine has been associated with a decrease in depression, anxiety, PTSD, OCD, chronic pain and other symptoms, with results lasting for days to weeks or longer. Ketamine may improve your symptoms of depression, anxiety, PTSD, OCD, or chronic pain but these effects may not be long-lasting.

C. Risk Management

You must report any unusual symptoms or side effects at once to the staff. Ask the treatment staff if you have any questions regarding the following:

- Your medication
- Your reaction to medication
- Any possible related injury
- Your participation in the clinical treatment

On the day of an infusion, you should <u>NOT</u> engage in any of the following.

•Driving- for a minimum of 4 hours after treatment ends
•Drinking alcohol
•Conducting business or participating in activities which require you to rely on motor skills and memory

D. Voluntary Nature of Treatment

You are free to choose the ketamine infusion or not. Please tell the doctor if you do not wish to receive the infusion. Not receiving the ketamine infusion does not affect your right to receive any other treatments offered.

E. Withdrawal of Treatment:

Your doctor or the treatment staff has the right to stop the treatment at any time. They can stop the infusion with or without your consent for any reason.

F. Patient Consent

I know that ketamine is not a FDA approved treatment for depression, anxiety, PTSD, OCD or chronic pain. I know that my taking part in this procedure is my choice. I know that I may decide not to take part or to withdraw from the procedure at any time. I know that I can do this without penalty or loss of treatment to which I am entitled. I also know that the doctor may stop the infusion without my consent. I have had a chance to ask the doctors and staff questions about this treatment. They have answered those questions to my satisfaction. The nature and possible risks of a ketamine infusion have been fully explained to me. The possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

- I acknowledge that I must obtain a ride home after my Ketamine treatment and I will not drive a vehicle within 4 hours of treatment ending.
- I agree to be under the care of a qualified medical provider while receiving ketamine infusions.
- I agree to Priority You to access all information pertaining to my mental healthcare and permission to speak to other medical providers to discuss my condition and the administration of Ketamine Infusion therapy.
- I am not currently taking a benzodiazepine such as Valium, Librium or Xanax and I have not taken a MAO inhibitor such as Phenelzine (Nardil), Tranylcypromine (Parnate) Isocarboxazid (Marplan) and Selegiline (Emsam) for more than two weeks.

- I understand that to achieve the desired results that a series of infusions are recommended and it is my full intent to complete the course of treatment.
- I understand that IV ketamine is not a substitute for continued behavioral medicine treatment. My medical providers will determine if any oral medications or other treatments may be stopped if my depression improves.
- I know that ketamine is not an FDA approved treatment for depression, bipolar disorder, PTSD or pain syndrome.
- I know that my taking part in this procedure is my choice.
- I know that I may decide not to take part or to withdraw from the procedure at any time.
- I know that I can do this without penalty or loss of treatment to which I am entitled.
- I also know that the doctor may stop the infusion without my consent.
- I also know that ketamine infusion therapy may not help my depression, bipolar disorder, PTSD or pain syndrome.
- I have had a chance to ask the doctor questions about this treatment, and those questions have been answered to my satisfaction.
- The possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me.
- No guarantees or assurances have been made or given to me about the results that may be obtained.
- I know the conditions and procedures of the treatment
- I know the possible risks and benefits from taking part in this treatment
- I know that I do not give up my legal rights by signing this form
- I state by my signature below that I have read, understand, and agree to the information above.

Print Name of Participant _____

Signature of Participant _____ **Date** _____

PHYSICIAN/THERAPIST STATEMENT

I have carefully explained the nature of subanesthetic ketamine therapy to this patient. I hereby certify that to the best of my knowledge, the individual signing this consent form understands the nature, conditions, risks, and potential benefits involved in participating in ketamine therapy.
A medical problem or language or educational barrier has not precluded a clear understanding of the subject's involvement in KAP.

PHYSICIAN SIGNATURE _____ DATE _____

Brent Agin, MD