



Ketamine Infusion Center

PRE-PROCEDURE PATIENT INSTRUCTIONS

- Come with an **empty stomach!** Do **NOT** eat (no food, no cereal, nothing) or drink anything (no water, no soda, no coffee, no tea, no Gatorade, nothing) at least **6 hours prior** to your procedure. Do **NOT** chew gum or suck on any candy/mint (no gum, no mint, no candy, no cough drops)
- Please **continue to take** your blood pressure pills, seizure medications, asthma medications, thyroid medication, pain medications as prescribed/scheduled with a sip of water.
- You should have an **ESCORT** to drive you home due to the nature of the procedure. **THIS IS MANDATORY!**
- Please arrive **30 minutes before** your appointment time. This allows us time to complete the necessary paperwork and nursing assessments prior to the procedure
- Wear loose fitting clothing the day of your procedure

Female Patients

- If you are pregnant or trying to get pregnant, you **MUST** inform us immediately.
- **Urine pregnancy test** will be done prior to the procedure at the facility.

Diabetic Patients

- If you are a **DIABETIC**, you need to let us know and we will schedule your procedure early in the morning. Take ½ of your long acting insulin the morning of your procedure only. **DO NOT** take any oral diabetic medications.
- Please, check your glucose (finger stick) at home on the procedural day.

HOME CARE INSTRUCTION AFTER THERAPY

ACTIVITY

- Take it easy today! **REST** for 24 hours. Then, increase activity as tolerated.
- **DO NOT** drive any vehicle or **DO NOT** operate any equipment for 24 hours.
- **DO NOT** make any important decision for 24 hours.

DIET & MED

- Resume normal diet as tolerated.
- Resume your medications as instructed including pain medication.

Patient's Name: _____ X _____ Date: _____



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Informed Consent for Ketamine Infusion Therapy

You have a pain problem and/or mood disorder that has not been relieved by routine treatments. Ketamine infusion therapy is now indicated for further evaluation or treatment of your pain and/or mood disorder. There is **NO** guarantee that Ketamine infusion therapy will cure your pain and/or mood disorder, and in rare cases, it could become WORSE, even when the infusion was completed in a technically perfect manner. The degree and duration of relief varies from person to person, so after the infusion therapy, we will reevaluate your progress, then determine if further treatment is necessary. Normal treatment is 6 infusions over a 2-week time span. Your physician will explain the details of the procedure listed below. Alternatives to the procedure include medications, physical therapy, psychotherapy, counseling, acupuncture, surgery, interventional treatments, etc. Benefits include increased likelihood of correct diagnosis and /or of decrease or elimination of pain or mood disorder. **Risks/Side Effects** are:

Common Side effects, greater than 1% and less than 10% hallucinations, vivid dreams and nightmares, nausea and vomiting, increased saliva production, dizziness, blurred vision, increased heart rate and blood pressure during infusion, out of body experience during the infusion, change in motor skills.

These symptoms dissipate when the infusion is stopped. If they are severe, another medication such as a sedative can be used to treat the symptoms. You should not drive the day of an infusion and can resume driving the following day.

Uncommon Side effects, greater than 0.1% and less than 1%

rash, double vision, pain and redness, pain and redness in the injection site, increased pressure in the eye, jerky arm movements resembling seizure.

Uncommon Side effects, greater than 0.01% and less than 0.1%

allergic reaction, irregular or slow heart rate, arrhythmia, low blood pressure, cystitis of the bladder: inflammation, ulcers, and fibrosis.

The incidence of serious complications listed above requiring treatment is low, but it may still occur. Your physician believes the benefits of Ketamine Infusion Therapy outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done. **I have read or had read to me** the above information including the Pre-Procedure Patient Instruction page. **I UNDERSTAND** there are risks involved with the Ketamine infusion, to include rare complications, which may not have been specifically mentioned above. The risks have been explained to my satisfaction and I accept them and consent to the Ketamine Infusion Therapy. The options, risk and benefits of the Ketamine Infusion Therapy have been discussed with me. All my questions have been answered to my full satisfaction. By signing this request form, I am indicating that **I understand** the contents of this document, agree to its provisions and consent to the administration of Ketamine. I am also acknowledging that the practice of anesthesiology, medicine and pain management is not an exact science and that no one has given me any promises or guarantees about the administration of Ketamine or its results. All blanks or statements requiring insertion or completion were filled in before I signed this consent and all of my questions have been answered to my satisfaction. I have been advised not to operate machinery, drive a car, and/or make important decisions for at least 24 hours after the infusion therapy.

I have read and understand the Informed Disclosure for Ketamine IV Therapy that I was given prior to my treatment.

Patient's Name: _____ **X** _____ **Date:** _____
Physician's Name: _____ **X** _____ **Date:** _____
Witness: _____ **X** _____ **Date:** _____