Informed Consent
Therapeutic IV Ketamine Infusion for chronic pain

I, _____ hereby give my consent to the following procedure

IV KETAMINE infusion for the treatment of Chronic pain due to_____

I understand the risks include but are not limited to: Drug reaction, pain, bleeding, infection, bruising at the IV infusion site, elevated blood pressure and heart rate. In very rare cases loss of consciousness, heart attack and death

I also understand that the potential side effects from infusion of ketamine may include: confusion, dysphoria, bad dreams. Furthermore by signing below I am confirming that I have received and reviewed the pre-infusion instructions, post infusion instructions and that I am able to fully comply. 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 I may not drive nor operate machinery for at least 24 hours after my infusion is completed. And that I will only be discharged to the care of a responsible adult.
I understand that good results are expected but not guaranteed. My pain may not improve with IV ketamine infusion even if I follow the complete treatment protocol
I understand that to achieve the desired results that a series of infusions are needed and it is my full intent to complete the course of treatment. By signing this document I am giving consent for such a series.
I understand that IV ketamine is not a substitute for continued treatment by my pain physician and that other treatments or therapy may be required. My pain management physician will determine if any oral medications or other treatments may be stopped if my pain improves.

Planned course of treatment:

Infusion length: ☐90min ☐120min ☐ 4hours ☐ 6hours ☐Other_____

Infusion frequency: ☐ twice weekly on: ☐ Monday/Wednesday or ☐ Tuesday/Thursday
☐ Four times weekly: Monday through Thursday
Other protocol:_____

Total number recommended infusions: ☐as needed ☐2 ☐4 ☐6 ☐ 8 ☐12 other:_____

_____
Patient Name: PRINT

_____ Date/time_____
Patient Signature or Guardian

_____ Date/time_____
Physician

_____ Date/time_____
Witness