



Paperflower Psychiatry, LLC.

Informed Consent Form for Ketamine-Based Treatments

Patient's Name: _____

Date of Birth: _____

Date of Consent: _____

Purpose of This Consent

This form confirms that I understand the **nature, risks, benefits, and alternatives of receiving ketamine-based treatment** through FYS, including Intramuscular (*IM*) Ketamine and intranasal Spravato (*Esketamine*). My provider has discussed this information with me, and I have had all my questions answered.

Overview of Treatment Options

1. Intramuscular (*IM*) Ketamine

- Off-label use for treatment-resistant depression, PTSD, anxiety, and other conditions
- Administered via injection under medical supervision
- Typically paired with Ketamine-Assisted Psychotherapy (*KAP*)

2. Spravato (*Esketamine*)

- FDA-approved for treatment-resistant depression and depression with suicidal ideation
- Administered via intranasal spray in a REMS-certified facility
- Must be taken with a daily oral antidepressant

1. Purpose of Treatment

I understand that the goal of ketamine-based treatment is to reduce symptoms of mental health conditions that have not responded to other treatments. No guarantee of improvement is given, and results vary from person to person.

2. How It Works

- Ketamine impacts glutamate receptors in the brain, leading to temporary dissociation and neuroplastic changes.
- Spravato works similarly but is only administered under supervision.
- Multiple treatments are often required.

3. Potential Benefits

- Possible symptom relief from depression, anxiety, PTSD, or suicidal thoughts
- Enhanced access to and effectiveness of psychotherapy
- Increased insight and emotional clarity

4. Potential Risks and Side Effects

Common: Dizziness, nausea, dissociation, sedation, increased blood pressure, headache, temporary confusion

Less Common but Serious: Panic, hallucinations, hypertensive crisis, bladder irritation (long-term use), allergic reaction, misuse risk

Spravato-Specific: Nasal discomfort, metallic taste, higher sedation risk



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5. Safety & Monitoring

- I will not drive or operate machinery until the next day after treatment.
- I will not use alcohol, cannabis, or benzodiazepines 24 hours before or after treatment unless prescribed.
- Vitals will be monitored before, during, and after treatment.
- Emergency protocols and trained staff are in place.

6. Alternatives to Treatment

I have been informed of alternatives, including:

- Oral antidepressants/mood stabilizers
- Psychotherapy (CBT, EMDR, DBT)
- TMS or ECT
- Lifestyle and functional approaches

7. Voluntary Participation

- I understand treatment is optional and I may withdraw at any time.
- Declining ketamine treatment does not affect access to other services at FYS or Paperflower Psychiatry.

8. Emergency Protocols

- I understand EMS may be called if medically necessary.
- I agree to remain onsite for the required observation period and understand that I cannot leave the facility until I have been medically cleared and formally discharged by the provider:
 - **IM Ketamine:** Minimum 90 minutes
 - **Spravato:** Minimum 2 hours under supervision
 - **IM Ketamine:** Minimum 90 minutes
 - **Spravato:** Minimum 2 hours under supervision

9. Confidentiality

- My information is protected by HIPAA.
- Therapy content discussed during KAP is confidential and not shared for insurance or legal use unless required by law.

10. Consent for Sedation, Monitoring, Transport, and Evaluation

- I consent to sedation and observation as part of this treatment.
- I understand that I cannot drive myself and must arrange safe transport.
- I agree to complete a full medical and psychiatric evaluation before beginning treatment.



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11. Consent Renewal

- This consent is valid for 12 months or until there is a change in treatment plan.
- I understand that verbal confirmation will be obtained at each visit, and I may be asked to sign again after any protocol change or treatment lapse.

12. Release of Information (ROI) for KAP at Paperflower Psychiatry, LLC

I authorize my KAP therapist, FYS (Find Your Shine) or other, to exchange information with Paperflower Psychiatry, LLC in order to coordinate care during ketamine-assisted psychotherapy. This may include:

- Treatment planning, progress updates, or medical coordination
- Session notes or symptom tracking as relevant
- Safety concerns or emergency communication

This release:

- Is limited to the purpose of coordinating care for my KAP treatment
- Does NOT allow for release of information for legal, insurance, or billing outside of Paperflower Psychiatry, LLC unless separately authorized
- May be revoked by me in writing at any time
- Automatically expires 12 months from the date of my signature unless revoked sooner

Patient's Signature: _____

Date: _____