# LifeFusion

INFORMED CONSENT FOR KETAMINE THERAPY

Ketamine is an anesthetic agent. I will be receiving a subanesthetic (doses below the amount necessary for general anesthesia) dose that is tailored to me based on my weight, sensitivity, condition, and medications I am currently taking.

I understand Ketamine treatment for major depression, psychiatric conditions, drug dependency, chronic pain, or mental reset are considered investigational by the Food and Drug Administration (FDA).

I understand according to the literature, Ketamine is a widely and successfully used medicine and is helpful to approximately 70% of the people and the effects typically last for about 2 weeks. I may or may not experience the benefits and may have longer or shorter duration. I agree to work with my health providers to determine the effects and the benefits in continuing or discontinuing therapy based on the results.

Potential side effects from Ketamine include dizziness, bad dreams, perceptual disturbances, confusion, elevations in blood pressure, libido, euphoria, and nausea. These side effects mostly disappear 80 minutes from infusion and Ketamine infusion is usually well-tolerated.

I understand there is a small risk of habituation with Ketamine.

I have been explained thoroughly and have been provided more detailed information about side effects and use of Ketamine for my condition and have had all my questions answered satisfactorily.

I understand that there are risks, complications, side effects, and dangers of any medical treatment including Ketamine which I have been clearly informed about and I accept these risks and want to proceed.

I voluntarily consent to the staff at LifeFusion to administer Ketamine to me and release them from any liability of the effects of treatment administration. No promises or guarantees as to the effectiveness or success of treatment have been made. I understand I or the staff have the freedom to stop therapy at any given time. I understand the duration of the infusion will be approximately an hour and it will be necessary for me to stay in the office after the infusion to be monitored which can be an additional 30 min-3 hours as needed.

*Patient Signature* _____ *Date*_____

*Witness* _____ *Date*_____

# LifeFusion

INFORMED CONSENT FOR INFUSION THERAPY

All patients have the right to participate in their own healthcare. Infusions and injections are designed to enhance my own health system. They contain vitamins, minerals, or amino acids to supplement my own diet to help provide optimal health. I understand I am receiving a standard formula designed to provide the desired nutrients. This is not a custom iv infusion based on my personal blood chemistry.

I understand infusion therapy is NOT for the cure of any disease or ailment.

I understand according to the literature, iv therapy has a much greater bioavailability because they are infused directly into the bloodstream and bypass the digestive system. They are widely and successfully used in medicine and may help take my wellness to the next level. People often notice the effects most for the first 48 hours. I may or may not experience these benefits or they may have a longer or shorter duration. I agree to work with my health providers to determine the effects and the benefits in continuing or discontinuing therapy based on the results.

Potential side effects from iv therapy include dizziness, nausea, vomiting, flushing, burning, elevations in blood pressure, increase libido, and mild euphoria. These side effects are usually mild and iv infusions are usually well-tolerated.

All my questions have been answered.

I understand that there are risks, complications, side effects, and dangers of any medical treatment including iv infusions which I have been clearly informed about and I accept these risks and want to proceed.

I voluntarily consent to the staff at LifeFusion to administer iv infusions to me and release them from any liability of the effects of treatment administration. No promises or guarantees as to the effectiveness or success of treatment have been made. I understand I or the staff have the freedom to stop therapy at any given time. I understand the duration of the infusion will be approximately 20-60 minutes.

*Patient Signature* _____ *Date*_____

*Witness* _____ *Date*_____

# LifeFusion

Patient Evaluation Form

**Patient to complete:**

First name: _____ Last name: _____

Street address: _____

City: _____ State: _____ ZIP: _____ Date of birth: _____

Phone: _____ Email: _____

You may contact me by: Phone Email

**Clinician to complete:**

Patient's Mood/Anxiety/Pain diagnosis (check all that apply):

Treatment-refractory depression*

Anxiety disorder

Post-traumatic stress disorder (PTSD)

Obsessive-compulsive disorder (OCD)

Bipolar Disorder

Post-partum Blues

Chronic Pain Syndrome

Migraine Headaches

Other: _____

* Treatment-refractory depression is generally considered two anti-depressant trials at maximum tolerated dose for a minimum of two months.

Have you had Electroconvulsive Therapy? Yes No

Does patient have an active substance abuse problem? Yes No

Does patient have a history of psychosis? Yes No

Current Medications:

_____

_____

If your patient is found to be appropriate for ketamine treatment, LifeFusion will administer treatment for this patient's Mood/Anxiety/Pain condition but will not take over the patient's mental or physical health care. Regardless, the patient will continue with your office for ongoing treatment of his or her mental health conditions.

Clinician's name (please print) _____

_____ _____

Clinician's signature Date

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Psychological Evaluation

1. **Sadness**
A. I do NOT feel sad
B. I feel sad much of the time
C. I am sad all the time
D. I am so sad I can't take it
2. **Pessimism**
A. I am not discouraged about my future
B. I feel more discouraged about my future than I used to
C. I do not expect things to work out for me
D. I feel my future is hopeless
3. **Past Failure**
A. I do not feel like a failure
B. I have failed more than I should have
C. As I look at my life, I see a lot of failure
D. I feel I am a total failure
4. **Loss of pleasure**
A. I enjoy doing things
B. I don't enjoy things as much as I used to
C. I get very little pleasure from things I used to enjoy
D. I can't get pleasure from things I used to enjoy
5. **Guilty Feelings**
A. I don't feel guilty
B. I feel guilty over many things I should have done
C. I feel guilty most of the time
D. I feel guilty all the time
6. **Self Dislike**
A. I like myself
B. I have lost confidence in myself
C. I am disappointed in myself
D. I dislike myself
7. **Self Critical**
A. I don't criticize or blame myself
B. I am more critical of myself than I used to be
C. I criticize myself for all my faults
D. I blame myself for everything bad that happens
8. **Suicidal thoughts**
A. I don't want to kill myself
B.I think about killing myself but would never
C. I would like to die
D. I want to kill myself if I have the chance
9. **Crying**
A. I don't cry any more than I used to
B.I cry more than I used to
C. I cry over little things
D. I feel like crying but I can't
10. **Agitation**
A. I am not agitated
B. I feel more restless than I used to
C. I am so restless or agitated it is hard to stay still
D. I am so restless I can't sit still

11. **Loss of Interest**
A. I have not lost interest
B. I am less interested in people and things than before
C. I have lost most of my interest in others
D. I have no interest in others
12. **Loss of Energy**
A. I have energy
B. I have less energy
C. I don't have enough energy to get things done
D. I have no energy
13. **Sleep**
A. I sleep all night
B. I sleep less than usual
C. I sleep all the time
D. I can't sleep
14. **Appetite**
A. I have good appetite
B.I have less appetite
C. I crave food all the time
D. I have no appetite
15. **Concentration**
A. I can concentrate
B. I can't concentrate like I used to
C. I have a hard time concentrating
D. I can't concentrate on anything
16. **Tired or Fatigue**
A. I am not tired
B. I get more tired easily
C. I am too tired to get things done
D. I am too tired to do anything
17. **Worthlessness**
A. I do not feel worthless
B. I do not have as much worth as I used to
C. I am more worthless than others
D. I feel utterly worthless