Dar a Luz
Health Center

Ketamine Infusion Therapy (KIT)
Informed Consent

Ketamine is approved by the FDA for use in children and adults for anesthesia and as a pain reliever during medical procedures. When administered in a low-dose infusion, ketamine is a medication that may provide relief of symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), acute and chronic pain.

Why Is Ketamine Being Recommended?

Numerous studies show that ketamine may be helpful in the treatment of depression, anxiety, PTSD, acute and chronic pain. When administered by vein over a period of 40 minutes (called an infusion), ketamine may help improve symptoms rather quickly. Improvements may last several days up to a few months. A series of infusions is recommended so that symptom relief has a longer duration of action. While the goal is improvement of symptoms, individual results cannot be guaranteed.

What Will Be Done?

You will be receiving ketamine by IV Infusion. This means an IV catheter will be inserted into a vein of your hand or arm and a ketamine fluid will be dripped into the vein. During the infusion your level of sedation, blood pressure, heart rate, oxygen concentration, heart rhythm and respirations will be monitored. After the treatment, you will need time to recover in the office and may take some sips of fluid during the recovery period. Current research recommends the you receive 6 treatments as the primary treatment episode. Additional maintenance treatments may or may not be suggested, occurring about once a month or less frequently as recommended by your infusion provider.

What Safety Precautions Must You Take?

- You may not eat or drink 4 hours before the infusion. Water is the only exception up to 2 hours before the infusion. This is to reduce the chances of nausea during the infusion.
- You may NOT drive a car, operate hazardous equipment, or engage in hazardous activities for at least 12 hours after each treatment as reflexes may be slow or impaired.
- Another adult and known to you will need to drive you home and must be present prior to your discharge.
- You must refrain from alcohol and cannabis at least 24 hours prior-to and following ketamine administration. We recommend 72 hours.
- You must refrain from other illegal substances during your ketamine infusion treatment.
- You must tell the clinic about all medications you are taking, especially narcotic pain relievers, benzodiazepines, barbiturates and muscle relaxers.
- If you take daily stimulant medication such as Ritalin or daily benzodiazepines, you must refrain on the day of your infusion.
- It is recommended that you have a mental health provider, but it is not required *unless you have been diagnosed with bipolar disorder, personality disorder, or have a history of psychosis, or are under the age of 18.*

What Are the possible Side Effects of Ketamine?

Possible side effects may include and are not limited to:

- Fast or irregular heart beats
- Increased saliva or thirst
- Increased or decreased blood pressure
- Lack of appetite
- Vivid dreams

- Headaches
- Confusion
- Metallic taste
- Irritation or excitement
- Constipation
- Floating sensation (“out-of-body”)
- Blurry or double vision
- Twitching, muscle jerks, and muscle tension
- Urinary frequency
- Nausea or vomiting
- Memory changes

Rare side effects of ketamine are:

- Allergic reactions
- Hallucinations
- Pain at site of injection
- Euphoria
- Increase in pressure inside the eye
- Involuntary eye movements
- Inflammation in the bladder
- Low mood or suicidal thoughts
- Respiratory complications

Side effects of receiving an IV are:

- Mild discomfort at the site of placement
- Infiltration (when the needle goes through the vein rather than in it)
- Bruising
- Infection

Important Notices and Agreements

KETAMINE INFUSION THERAPY IS NOT A COMPREHENSIVE TREATMENT FOR DEPRESSION, ANXIETY OR ANY PSYCHIATRIC SYMPTOMS. INITIAL

- Your ketamine infusions are meant to augment (add on to, not be used in place of) comprehensive psychiatric treatment. Therapy is a recommended adjunct. _____
- While receiving ketamine infusions, if you have previously been diagnosed with bipolar disorder, personality disorder, have a history of psychosis, or are under the age of 18, you agree to remain under the care of a qualified mental health provider. _____
- Psychiatric illnesses carry the risk of suicidal ideation (thoughts of ending one’s life) or thoughts of harming others. Any such thoughts you may have at any time during your ketamine infusion therapy, or at any point in the future, which cannot immediately be addressed by visiting with a mental health professional should prompt you to seek emergency care at an ER or to call 911. _____
- Ketamine use during pregnancy is contraindicated. Females who are not on reliable birth control will be asked to submit a urine sample for a pregnancy test prior to your first infusion and every 2 weeks thereafter. _____

My Consent for Ketamine Treatment is Voluntary:

My request for ketamine infusion treatments as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse ketamine treatments at any time. Any money I have deposited for future treatments will be refunded to me if I choose _____

not to proceed with future infusions. I have been advised that I can seek a second opinion from another provider before agreeing to have ketamine treatment and I am choosing to proceed at this time, with or without this second opinion. I have notified my mental health provider and/or primary care provider of my ketamine infusion therapy if I have one.

I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction.

I have had the opportunity to ask questions about this procedure. I consent and would like to proceed with ketamine infusion treatment.

_____ _____
Signature of Patient Printed Name

_____ _____
Date Time

_____ _____
Signature of Witness Printed Name

_____ _____
Date Time

The provider treating my symptoms of depression or anxiety or other psychiatric symptoms is:
□ N /A

_____
Name of Provider and Practice if Applicable

_____
Phone

_____
Address

12/19/25