POLARIS INSIGHT CENTER

Ketamine-Assisted Psychotherapy
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INFORMED CONSENT FOR KETAMINE LOZENGE TREATMENT

By signing this form, I acknowledge and agree to the following:

1. I have received and reviewed the Instructions for Home KAP and lozenge use. I agree to follow the directions from that document which include using eyeshades, headphones (if possible), and a music soundtrack that follows guidelines outlined by therapist(s) and KAP Home Instructions document.

2. I have had the opportunity to ask questions of at least one of the providers involved in my KAP treatment about home KAP sessions and any other questions related to ketamine and KAP and have received satisfactory answers.

3. I fully understand that the ketamine sessions can result in a profound change in consciousness and mental state and may result in some unusual psychological and physiological effects for a period of time.

4. I understand that I am to have nothing in my stomach for approximately 4 hours prior to my ketamine lozenge session.

5. I understand that I need to avoid using stimulants, benzodiazepines, and alcohol on the day of my lozenge session. It is also preferable to avoid these substances for about a day after the home session as well.

6. I agree not to engage in any driving or operation of machinery all day following the ketamine lozenge session.

7. I understand that I am to stay in a reclining or seated position while under the influence of the medicine. If alone or predominantly on my own, I understand that I need to be extremely careful and mindful about any movements, for example to the bathroom.

8. I understand that some people prefer to do KAP sessions completely on their own, and some prefer to have a support person present to watch over physical safety while under the influence of the medicine. Each option has its own pros and cons and I have

reviewed these with my provider. In the absence of a support person, it might be helpful to have someone in mind to call after the session for support if needed.

9. I agree to abide by the dosing and scheduling instructions given by my providers.

10. I understand that I am to keep my ketamine supply in a secure location, that this prescription is not to be shared with anyone and that lost or misplaced lozenges will not be replaced.

11. I understand that if my providers have any concern about the safety of my home lozenge use, they reserve the right to terminate this prescription and refer me to more appropriate care.

12. I agree to send an email to my providers following each lozenge session (unless otherwise agreed to with providers, as for example, once a week etc.) to share with my providers about the outcome of my experience.

13. I understand that an ongoing prescription is contingent upon monthly check-in meetings with at least one of the providers at the clinic.

14. I understand the risks and benefits of ketamine-assisted psychotherapy, and I freely give my consent to participate in KAP outlined in our information sheet and informed consent documents.

_____	_____	_____
(Patient Signature)	(Patient Name)	(Date)
_____	_____	_____
(Provider Signature)	(Provider Name)	(Date)