

Kahala Office Building, 4211 Waialae Avenue, Suite 208, Honolulu, Hawaii 96816

PH: 808.888.5228 F:808.732.6433 [www.kahalaclinic.org](http://www.kahalaclinic.org) (REV 09/21)

**Kahala Clinic Informed Consent**

**KETAMINE ASSISTED PSYCHOTHERAPY INFORMED CONSENT FOR SERVICES at the Kahala Clinic for Children and Family.**

Welcome to Kahala Clinic for Children and Family!

***At Kahala Clinic, our mission is to offer cutting edge, innovative mental health treatment for individuals suffering from a wide variety of psychological conditions as well as to provide services for those seeking personal growth, development, and self-actualization.***

The Kahala Clinic for Children and Family offers a comprehensive, solution and outcomes-focused approach to common life challenges. Each provider is governed by certain laws and regulations and by a code of ethics. The ethics code requires that we make you aware of certain office policies that may affect you. It is very important to us that all patients feel welcomed, safe, supported, and respected, and we will address any concerns that might arise in this regard. Please take time to read this document, as well as the general i*nformational document provided* as it contains important information and a detailed description of Ketamine Assisted Psychotherapy (KAP). It is also recommended for all prospective patients to do independent research into ketamine’s potential and properties as a treatment, as well as the more detailed descriptions of KAP in its entirety. Lastly, it is highly encouraged that prospective patients ask any questions that may arise.

# **Treatment Guidelines:**

I agree to the following guidelines provided below for my pre- and post-ketamine treatment sessions. I understand that failure to abide by these guidelines can result in medical risk, postponement, or cancellation of treatment.

## **Pre-KAP Guidelines:**

* Nausea is a common side effect of ketamine, with some studies indicating that about 30% of individuals will experience it. If you have previously experienced nausea on ketamine, or are at higher risk for experiencing nausea (i.e easily get motion sick), then discuss with your doctor about taking an antiemetic such as ondansetron (Zofran) before ketamine sessions.
* You may drink clear liquids for the hour prior to treatment but avoid food 3-4 hours prior to treatment.
* Consult doctor on what medications you may need to discontinue temporarily before a treatment[[1]](#footnote-0)
* Recommend avoiding caffeine, alcohol, sedatives, cannabis, and/or violence on TV, music, and movies for 24 hours prior to treatment (If concerned for substance withdrawal, consult with physician beforehand)
* Meditation or other mind body practices are encouraged in order to prepare and quiet the mind for what one can anticipate experiencing during a treatment

# **Following your KAP treatment:**

* Avoid operating a motor vehicle or heavy machinery for 12-24 hours following treatment.
* There is a neuroplastic window 48-72 hours following Ketamine treatment where there is opportunity to reflect on and reinforce new brain pathways, thought patterns, and behavior.
* The benefits of KAP are extended when patients engage in a variety of self-care practices during and after the treatment such as:
  + Time in nature, with loved ones, journaling, artwork, meditation/ mind body practices.
  + Light nutritious food, hydration, and adequate sleep

# **Adverse Effects:**

Ketamine has an extensive record of safety. However, all pharmaceuticals contain some risk of side effects.[[2]](#footnote-1) [[3]](#footnote-2) Ketamine affects individuals differently. Some of the listed side effects are dose and setting dependent, and less relevant to KAP, but added for completeness.

Common side effects:

* Nausea
* Vomiting
* Dizziness
* Diplopia (double vision) and slurred speech
* Drowsiness
* Transient Increased heart rate and blood pressure.
* Confusion
* Euphoria
* Vivid dreams and/or nightmares
* Visual and auditory hallucinations

Other side effects may include:

* Confusion and clumsiness
* Anxiety
* Dysphoria
* Lowered sensitivity to pain
* Skin: pain at site of injection, redness, swelling or rash

Possible long term effects: (typically observed only in anesthetic or heavy recreational use)

* Flashbacks
* Poor sense of smell
* Mood/personality changes
* Poor memory and thinking
* Abnormal liver or kidney function
* Bladder problems
* Abdominal pain
* Tolerance and/or dependance
* Financial, work, and social problems

List of rare side effects:

* Allergic: anaphylaxis, breathing difficulties, swelling, hives
* Cardiovascular: arrhythmias, blood pressure elevation, bradycardia, hypotension, left ventricular dysfunction for patients with heart failure, respiratory arrest, cardiac arrest
* Muscular: stiffness and spasms
* Neurologic: confusion, seizures
* Ophthalmologic: increased intraocular pressure
* Psychiatric: amnesia, confusion, depression, disorientation, dysphoria, dissociative state, emergence phenomena, hallucination, flashbacks, unusual thoughts, fear, excitement, irrational behavior, insomnia.
* Respiratory: apnea, increased laryngeal, and tracheal secretions, laryngospasm, respiratory depression

# **Fees due prior to or at time of service:**

If insured by HMSA, UHA, or HMAA then part of services rendered will be covered by insurance. Patient is responsible for paying an additional amount of $350 per ketamine session. Preparation and integration sessions will be billed like normal appointments and you will be responsible for your typical co-pay, or if self pay, $275/ visit.

If a patient does not have insurance accepted by the clinic then the fees are as follows: $700 for physician supervised session.

**Card Information:**

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: □ Master Card □ Visa

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV: \_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (permission to charge card for KAP sessions)

# **Acknowledgement**

## **Termination of Treatment:**

I acknowledge that I have the right to end treatment at any time without any moral, legal or financial obligation other than those already accrued. I, too, understand that my physician reserves the right to terminate treatment at any time without my consent.

By signing this agreement you agree and acknowledge that you have had the chance to carefully consider this treatment and the questions and/or concerns you have regarding the services or this agreement have been answered and resolved to your satisfaction.

By signing this form, I also agree that:

1. I have fully read this informed consent form describing subanesthetic ketamine therapy.
2. I have had the opportunity to question one of the persons in charge of the ketamine therapy and have received satisfactory answers.
3. I fully understand that the ketamine sessions can result in a profound change in mental state and may result in unusual psychological and physiological effects.
4. I understand that I can request a signed copy of this form at any time.
5. I understand the risks and benefits, and I freely give consent to participate in ketamine  
   therapy outlined in this form.
6. I understand that I may withdraw from ketamine therapy at anytime up until the actual  
   injection has been given.
7. I have received the Pre-treatment and Post-treatment instructions.
8. I will not eat 4 hours prior or drive for at least 12 hours following administration of ketamine.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. <https://www.ketamineintegrativemedicine.com/blog/how-to-prepare-for-your-ketamine-treatment> [↑](#footnote-ref-0)
2. <https://adf.org.au/drug-facts/ketamine/> [↑](#footnote-ref-1)
3. <https://www.ncbi.nlm.nih.gov/books/NBK470357/> [↑](#footnote-ref-2)