**Informed Consent and Patient Agreement for Treatment with Spravato**

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First Name Last Name M.I. DOB Date

I have talked with my licensed medical provider (MD/PA/NP) about taking a medicine called Spravato for depression and/or suicidal ideation. I understand that this consent form and patient agreement is important and shows that I am making an informed decision to use Spravato.

\_\_\_\_\_ I understand that I must follow my providers treatment regimen and guidelines or

termination of my Spravato treatments may occur.

\_\_\_\_\_ I understand Spravato is approved by the Food and Drug Administration (FDA) for the

treatment of depression and/or suicidal ideation. Spravato works best when used in conjunction with oral antidepressant medication and psychotherapy.

\_\_\_\_\_ I agree to abstain from drugs and alcohol while utilizing Spravato. I understand I am to

withhold benzodiazepines (ie. Xanax, Ativan), stimulants (ie. Adderall, Ritalin), or other sedative medication twelve hours prior to my Spravato treatment, as it may cause further side effects such as excessive sedation or high blood pressure.

\_\_\_\_\_ I understand that Spravato may cause side effects including but not limited to sedation,

dissociation, high blood pressure, headache, nausea/vomiting, or suicidal ideation.

\_\_\_\_\_ I understand I am required to remain at the office for a minimum of two hours following

 each Spravato administration.

\_\_\_\_\_ I understand I must have a reliable driver to take me home after each treatment. Taxi

services including Uber/Lyft are not acceptable. I have been instructed to rest & relax,

and not to drive or operate heavy machinery until the day after Spravato administration.

**My signature below acknowledges consent to treatment with Spravato.**

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_