361 WELLNESS
NEUROWELLNESS SPA

361-986-3691
361Wellness.com

POST INFUSION INSTRUCTIONS

Congratulations on resetting your life!!! The benefits of your treatment have already begun even though you may not notice it yet.

You may experience some side effects from your infusion of ketamine even if you are not experiencing any currently. Side effects you may encounter include:

- disorientation or confusion
- heart rate changes or palpitations
- unusual muscle movements
- insomnia
- unusual dreams or nightmares
- redness or swelling at IV site
- nausea
- headaches
- anxiety

If you experience any of these symptoms, please document them: duration, severity, alleviating factors. We will want this information for future analysis and treatment modifications.

More severe possible side effects include:

- seizure like activity
- changes of heart rhythm
- increased or decreased blood pressure
- swelling from allergic reaction
- changes or difficult breathing

IF YOU HAVE ANY SYMPTOMS THAT REQUIRE IMMEDIATE ATTENTION, CALL 911.

If you have any concerns or questions about post treatment expectations, you can call our clinic at 361-986-3691. If you have any concerns or questions after clinic hours, and need evaluation by a physician, please go to nearest Urgent Care Clinic or ER. If you have any questions otherwise after hours, please call back next business day.

Due to possible confusion or memory problems, we do not recommend you engage in any activities that may affect your decision making process, including financial decisions, legal decisions, employment decisions, etc.

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POST INFUSION INSTRUCTIONS

I have read the Post Treatment Instructions and agree to follow them. If I choose to stray from these recommendations, I understand I am going against medical advice and therefore am solely responsible for any consequences caused by my actions:

____ ________________

Patient Name Date

____ ________________

361 WellnessTeam Member Date

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CONSENT FORM

I, ______________________________________, have been educated about ketamine infusions. I have been offered to address any of my questions and all questions have been addressed. I understand 361 Wellness suggests to provide an IV infusion of ketamine to me in an attempt to provide benefit for my diagnosis/diagnoses:

- ☐ Depression
- ☐ PTSD
- ☐ Mania
- ☐ Migraine/Headache
- ☐ Post-partum Depression
- ☐ Other
- ☐ Neuropathic Pain
- ☐ Bipolar
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Pelvic Pain

I understand ketamine has been used for decades as a medicine and is FDA approved as an anesthetic agent. However, for the purposes of my infusion, ketamine has not been approved by the FDA. I understand my treatment is not a clinical study, but a procedure performed by 361 Wellness and is not followed by any Institutional Review Board (IRB) or FDA. I also understand 361 Wellness plans to use ketamine as an infusion, or constant drip.

The most common side effects include increased nausea, vomiting, saliva production, vivid or changes in dreams, dizziness, nightmares, increased and /or decreased heart rate, increased and/or decreased blood pressure, unusual movements, altered perceptions during infusion. Less common side effects include rash, eye pressure increases, vision changes, seizure like movements, breathing changes or difficulties, rhythm changes of the heart, allergic reaction requiring other medical interventions, heart attack, stroke, and death. I understand these side effects are much more likely to occur at doses much higher than I will be receiving during my infusion, and these side effects are much more likely to occur with one quick administration of ketamine instead of the slow infusion like I will be receiving over approximately 60-90 minutes.

Patients with a history of drug non-compliance or abuse are at increased risk of developing dependence to ketamine. I understand, there is no guarantee of benefit, I may not obtain any benefit, and my symptoms may get worse. Possible complications of the procedure include but are not limited to bleeding, infection, bruising, damage to nerves or surrounding tissue, failure to provide benefit, requirement of hospitalization, heart attack, stroke, paralysis, and death.

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CONSENT FORM

I understand 361 Wellness is recommending to follow published literature of 6 treatments over 2-3 weeks to maximize benefit, but I may choose to alter my treatment schedule at any time with the understanding this may decrease my benefit. I also understand my ketamine infusion treatment is a cash option only, and there will be no refunds for any failure of treatments. If I choose to give a testimonial about my treatment, 361 Wellness has the right to share the testimonial on the company social media or website.

______________________________	______________
Patient Name	Date
______________________________	______________
Name of Driver	Date
______________________________	______________
361 WellnessTeam Member	Date

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? ***(Use "✓" to indicate your answer)***	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ________ + ________ + ________

=Total Score: ________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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BDI-II

Date:

Name: ________________ Marital Status: ________ Age: ______ Sex: ______

Occupation: ________________ Education: ________________

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_________ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

3 4 5 6 7 8 9 10 11 12 A B C D E

________ Subtotal Page 2

________ Subtotal Page 1

________ **Total Score**

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DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:
Does the pain have one or more of the following characteristics?

	YES	NO
Burning	☐	☐
Painful cold	☐	☐
Electric shocks	☐	☐

QUESTION 2:
Is the pain associated with one or more of the following symptoms in the same area?

	YES	NO
Tingling	☐	☐
Pins and needles	☐	☐
Numbness	☐	☐
Itching	☐	☐

EXAMINATION OF THE PATIENT

QUESTION 3:
Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	YES	NO
Hypoesthesia to touch	☐	☐
Hypoesthesia to pinprick	☐	☐

QUESTION 4:
In the painful area, can the pain be caused or increased by:

	YES	NO
Brushing?	☐	☐

YES = 1 point
NO = 0 points

Patient's Score: /10

INFUSION LOG

Patient Name: ______________________

Date: ______________________

Treatment Number: ______________________

Pre-Procedure				
Date	HR	SpO_2	BP	Infusion Name

*******Patient Asked About Pregnancy Status Prior to Infusion?******* **Y / N**

*******If Yes, Results of UPT******* **+ / -**

Infusion Start Time:__________ Infusion Stop Time:___________

Infusion Time	HR	SpO_2	Rate (cc/hr)	Total Volume	Side Effects/Notes:
1-10 min					
11-20 min					
21-30 min					
31-40 min					
41-50 min					
51-60 min					
61-70 min					
71-80 min					

Post-Procedure							
Time	HR	SpO_2	BP	Total Volume	Total Dose K (mg)	Total Dose A/V (mg)	Additonal Meds Given

PMH reviewed:	Meds Reviewed:	Allergies:

Notes: ____

____

____

Provider Signature: ______________________