RAINBOW MANDALA THERAPIES

CANBERRA PSYCHOLOGY SERVICES
Therapy and Assessment

KSET Screening

If prefilled by patient, clinician should review.

Patient Name	
Date of Birth	

Complete when assessing suitability for ketamine treatment.

Have you experienced or currently experience any of the following:		
Hallucinations (e.g. seeing, hearing, smelling or tasting things that are not present in reality	Yes	No
Elevated/irritable mood (e.g. euphoria, agitation, recklessness, increased energy, increased confidence)	Yes	No
Dissociation – induced by a drug/substance (e.g. feeling disconnected from self, body, thoughts, surrounding.)	Yes	No
Dissociation – not related to drug/substance use.	Yes	No
High blood pressure (hypertension)	Yes	No
Heart/cardiovascular condition	Yes	No
Seizures/stroke/head injury/neurological disorder.	Yes	No
Glaucoma	Yes	No
Liver problems	Yes	No
Kidney problems	Yes	No
Bladder problems or problems passing urine (e.g. pain, burning, irritation, increased frequency, difficulties passing and/or changes in colour/smell of urine)	Yes	No
Alcohol or drug misuse	Yes	No
Chronic pain	Yes	No
Problems with memory and/or concentration	Yes	No
For Females: Current Pregnancy	Yes	No
For Females: Currently breastfeeding	Yes	No

Have you ever received or used ketamine for any reason? Tick all that apply:				
☐	No previous use (please Continue on to Allergies section)			
☐	Depression treatment, if yes, was it useful?	Yes	No	
☐	Pain management, , if yes, was it useful?	Yes	No	
☐	Other medical reasons (e.g. anaesthesia, sedation) Please specify			
☐	Recreational use			

Please fill in the table to the best of your ability regarding past ketamine use (as relevant):

	Depression Treatment	Pain Management	Recreational Use
When did you last receive ketamine?	☐ Last 3 months ☐ 3-12 months ago ☐ > 12 months ago	☐ Last 3 months ☐ 3-12 months ago ☐ > 12 months ago	☐ Last 3 months ☐ 3-12 months ago ☐ > 12 months ago
How many times in total (lifetime)?			
Route (e.g. injection, infusion 'drip', nasal, oral)			
Highest does received			
Did you have any adverse reactions?	☐ No ☐ Yes, specify	☐ No ☐ Yes, specify	☐ No ☐ Yes, specify
Have you ever craved ketamine?	Yes	No	

If "Yes", please specify how recently:

Current use of medications or supplements? If "yes" please list all medications and supplements below	Yes	No

Allergies	Clinician Name	
	Signature	
	Date	