

AUTHORIZATION TO TREAT AND RELEASE MEDICAL RECORDS

RETURN TO MIND & BODY WELLNESS CENTER with copy of patient's current H&P

FAX: 402-502-3112

EMAIL: admin@MindBodyWellnessOmaha.com

_____ DOB ___/___/___ has contacted Mind & Body Wellness Center regarding a treatment

plan for a Ketamine Infusion(s) for one of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Treatment Resistant Depression (TRD) | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Post Addiction Withdrawal Syndrome (PAWS) | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Severe Anxiety |
| <input type="checkbox"/> Single Follow-up Infusion <i>(This patient has undergone the protocol of 6 and is following up at least 4 weeks later)</i> | <input type="checkbox"/> Other: _____ |

The protocol calls for up to (6) forty-minute customized Ketamine IV infusions in a 2-3 week span. The patient's infusions and monitoring are conducted by a certified nurse anesthetist. During the patient's journey a guide will also be there to assist and support the needs of patient. Therapists and mental health coaches are also available should the patient desire to engage and reflect.

** Suicidal ideations are urgent and a safe intervention should be conducted as soon as possible. The research and literature shows, after a single Ketamine infusion, suicidal ideations are far less intense.

HEALTH CARE PROVIDER INFORMATION

Provider Name: _____

Provider Phone/Fax Number: _____

Provider Address (street, City, ST, zip): _____

PATIENT: By signing below you allow the above health care provider to share medical information with Mind & Body Wellness Center

PROVIDER: By signing below: A.) You concur that the patient has the diagnosis that is checked mark above thus qualifying them for Ketamine treatment at Mind & Body Wellness Center B.) You also agree that the patient aforementioned is in good health standing for intravenous Ketamine infusion(s).

Patient: _____ Date: _____

Provider: _____ Date: _____

We here at Mind & Body Wellness Center want to be as comprehensive as possible. By including the patient's primary care provider and if applicable their primary mental health professional we feel the patient's best interests will be held as the primary focus. We will follow up with the patient's health care providers keeping with continuity of care. Please feel free to contact us with any questions (402) 203-5269.