SPRAVATO® (Esketamine) Treatment Consent and Acknowledgment

Patient Name: _____ DOB: _____ Date: _____

I understand that SPRAVATO® (esketamine) is a prescription medication used to treat certain depressive disorders and is administered under medical supervision in a certified treatment setting. The purpose, potential benefits, risks, and alternatives have been explained to me, and I understand that treatment outcomes cannot be guaranteed.

Potential side effects may include dissociation, sedation, dizziness, increased blood pressure, nausea, headache, anxiety, and temporary impairment of attention, judgment, thinking, or motor coordination. I understand that other risks may exist and that I should promptly report concerning symptoms to my treatment team.

I understand that I will be monitored following each treatment session as required by clinical guidelines and the SPRAVATO REMS Program. I agree not to drive, operate machinery, sign important legal documents, or engage in activities requiring full alertness until the day after treatment and after a restful night's sleep. I am responsible for arranging transportation home following treatment.

I agree to provide accurate medical information, inform my provider of any changes in my health or medications, follow treatment recommendations, attend scheduled appointments, and report any adverse effects or concerns.

By signing below, I acknowledge that I have read and understood this form, have had the opportunity to ask questions, and voluntarily consent to receive SPRAVATO treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____