St. Clair County Community Mental Health Authority

Consent for Spravato Treatment

Individual: _____ Case #: _____ Date: _____

I agree to participate in the Spravato treatment plan provided by St. Clair County Community Mental Health Authority (SCCCMHA), a certified Spravato treatment center, to manage Treatment-Resistant Depression (TRD) or depressive symptoms secondary to major depressive disorder (MDD) including suicidal thoughts or actions. I understand that Spravato is a U.S. Food and Drug Administration approved treatment for my condition. I understand the Spravato is an anti-depressant medication which is administered as a nasal spray. I understand that Spravato will be provided to me at SCCCMHA, and I understand that I am not permitted to take Spravato home with me. I understand that I will spray the medication in my nostrils under the direct supervision of a qualified SCCCMHA staff member. I understand I will require monitoring by a qualified SCCCMHA staff member for a period of at least 2 hours after the medication has been administered.

I understand that participation in the Spravato treatment plan is contingent upon my adherence to the following plan requirements:

1. Participants will receive mental health treatment from SCCCMHA during the course of their Spravato treatment plan. Some Spravato recipients receive maintenance treatment, which has been ongoing for years. During the Spravato treatment period, participants will not seek or receive mental health treatment from any mental health professional (psychiatrists, therapist, counselors or any other providers) not employed by SCCCMHA.
2. Participants will self-administer Spravato medications (nasal spray) at SCCCMHA under the direct supervision of a qualified SCCCMHA staff member.
3. Participants will remain at SCCCMHA for an observation period of at least 2 hours following each self-administration of Spravato. Observation of participants will be completed by a qualified SCCCMHA staff member who will ask participants if they are experiencing any side-effects to the medications such as dissociation, dizziness, nausea, sedation, reduced sense of touch and sensation, anxiety, lack of energy, increased blood pressure, vomiting, or any other issues that may arise following treatment.
4. Participants will not leave the observation area until they are medically cleared by a qualified SCCCMHA staff member.
5. During the observation period, participants will be monitored in a room with other Spravato treatment plan participants.
6. Participants will ensure a support person is available to drive them to each Spravato treatment session and drive them home after each Spravato treatment session is complete.
7. Participants will not drive a motor vehicle for a period of 24-hours following a Spravato treatment session.
8. Participants will provide a urine specimen for completion of a urine drug screen if ordered by their SCCCMHA prescriber.
9. Participants may be discharged from the Spravato treatment plan if they are unable to follow the Spravato treatment plan standards outlined above.
10. Participants may choose to return to their previous mental health provider after completion of the Spravato treatment plan.

I fully understand that Spravato treatment does not guarantee a successful outcome. I understand that side-effects can be expected from this treatment. I understand that I can learn more about Spravato treatment by visiting www.spravato.com.

My signature below confirms that I have received a written Spravato Medication Guide, I have had the opportunity to discuss the potential benefits and risks of Spravato treatment with my prescriber, I agree to participate in the Spravato treatment plan and I agree to follow the Spravato treatment plan requirements.

Recipient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

Witness Signature: _____ Date: _____