Work Star
Injury Recovery Center

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law and best practices regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will be relying upon this Agreement in treating my pain symptoms.

I understand that if I break: this Agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, my doctor may recommend a drug-dependence treatment program for me.

I will fully communicate openly and honestly with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the prescribed medicine is helping to relieve the pain. I will not use any illegal or controlled substances, including marijuana, cocaine, etc. while taking my pain medicine as doing so may result in my inability to think clearly, become sleepy, and risk injury to myself or others. I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss, theft or use by others, especially children. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends or before my next scheduled appointment.

I, _____, agree to use
(PRINT FIRST & LAST NAME)

_____ Pharmacy,

located at _____

telephone number _____, for filling prescriptions for all of my pain medicine.

Clinical Service Center - 91·2135 Fort Weaver Road - Suite 170 - Ewa Beach, HI 96706 - Phone: (808) 676-5331 - Fax: (808) 671·2931

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I authorize my doctor, spouse, family members, and my pharmacy to cooperate fully with any local, state, or federal law enforcement agency, including the Hawaii Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with the prescribed program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time as determined by my doctor.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____, _____
Month Year

Patient signature: _____

Physician signature: _____

Witnessed by: _____

Print

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