995 Worthington Street, Springfield, MA 01109
Telephone 413-734-5376 FAX 413-737-7949

Emergency Medical Treatment Refusal

Participant Name: ________________________________ Date: __________________

Staff Name: ______________________________________ Title: ___________________

___________________________________has been offered Emergency Medical Treatment for
(Participant Name) this / these reasons:

____

____

____________________________ is voluntarily refusing Emergency Medical Treatment at this time.
(Participant Name)

1. Refusing Emergency Medical Treatment will not stop you from receiving Emergency Medical Treatment in the event you change your mind and / or you start to experience pain or discomfort following this signed refusal.
2. Refusing Emergency Medical Treatment is stating that at this time you feel healthy enough to go on with your daily living routine.
3. Refusal will not impact on your overall participation with your MHA program or future involvement with MHA.
4. **If your health status changes notify your program staff immediately or call 911 for immediate treatment.**

Participant Signature: _____________________________ Date: _______________

I have offered the opportunity to secure Emergency Medical Treatment to the above mentioned participant. I have explained to this participant that refusing Emergency Medical Treatment does not preclude them from receiving services and that IF they start to experience any new and / or additional signs or symptoms of injury (including but not limited to pain, but also swelling, or bleeding, or impaired vision, or dizziness or anxiety or shortness of breath etc) they are to notify program staff immediately or call 911 for additional support. I agree to coordinate with the participant and the Program Supervisor a follow up visit to the participant in the next 24 hours.

Staff Signature: __________________________________ Date: _____________

Cc:
Participant, Program Supervisor, Nurse Manager, Quality Improvement Coordinator