ADVANCE DIRECTIVE FOR HEALTHCARE
--NEW MEXICO—

EXPLANATION

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make healthcare decisions for you. This form lets you do EITHER or BOTH of these things. It also lets you express your wishes regarding the designation of your primary physician.

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you have already signed a valid durable power of attorney for healthcare and/or right to die statement (living will), these statements are still valid. If you use this form, be sure to sign it and date it.

YOU DO NOT HAVE TO SIGN ANY FORM. If you do not sign a form or tell your doctor who you want to make your healthcare decisions (or if someone you identify is not reasonably available), New Mexico law allows a family member who is reasonable available, to make your healthcare decisions. Family members are selected in the following order: 1) spouse, 2) significant other, 3) adult child, 4) parent, 5) adult brother or sister, 6) grandparent. If no family member is available, a close friend may act as a surrogate.

PART 1: POWER OF ATTORNEY FOR HEALTHCARE

***Part 1** of this form is a **power of attorney for healthcare**. It lets you name another individual as agent to make healthcare decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now, even though you are still capable. You may also name alternate agents to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a healthcare institution at which you are receiving care.*

This form has a place for you to limit the authority of your agent. If you do not limit your agent's authority, your agent may make <u>all</u> healthcare decisions for you.

DESIGNATION OF AGENT: I appoint the following person as my agent to make healthcare decisions for me:

_____

(name of agent)

_____

(street address) *(city)* *(state)* *(zip code)*

_____

(home phone) *(work phone)*

If I revoke my agent's authority, or if agent cannot or will not make a healthcare decision for me, then I appoint these persons as my alternative agents, to serve as follows:

_____	_____
(name of first alternative agent)	*(name of second alternative agent)*
_____	_____
(street address)	*(street address)*
_____	_____
(city, state, zip)	*(city, state, zip)*
_____	_____
(phone numbers: home/work)	*(phone numbers: home/work)*

AGENT'S AUTHORITY: *If you do not limit your agent's authority, your agent will have the right to:*

(1) consent or refuse consent to any medical care, treatment, service or procedure, such as:

- *diagnostic tests*
- *surgery*
- *medication*
- *hospitalization*
- *nursing care*
- *orders not to resuscitate*
- *life saving and life prolonging medical treatment*
- *the provision, withholding or withdrawal of artificial nutrition and hydration*
- *all other forms of healthcare to keep me alive*
- *home healthcare*

(2) select or change healthcare providers and institutions.

My agent may make all healthcare decisions for me, including obtaining and reviewing medical records, reports and information about me, except to the extent I limit my agent's authority as follows:

(add additional pages if needed)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified healthcare professional determine that I am unable to make my own healthcare decisions.

[ ] If I initial this box, my agent's authority to make healthcare decisions for me takes effect immediately.

AGENT'S OBLIGATION: My agent shall make healthcare decisions for me based on this **power of attorney for healthcare**, any healthcare instructions I give in *Part 2* of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

NOMINATION OF A GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated

PART 2: INSTRUCTIONS FOR HEALTHCARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my healthcare, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my healthcare providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choices I have initialed below in one of the following three boxes:

[ ] (a) I CHOOSE NOT To Prolong Life. I do not want my life to be prolonged.

[ ] (b) I **CHOOSE To Prolong Life.** I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

[ ] (c) I CHOOSE To Let My Agent Decide. My agent under my power of attorney for healthcare may make life sustaining treatment decisions for me.

ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above **NOT** to prolong life, I also specify by marking my initials below:

[ ] I DO NOT want artificial nutrition (food) **OR**

[ ] I DO want artificial nutrition (food).

[ ] I DO NOT want artificial hydration (water) unless required for my comfort **OR**

[ ] I DO want artificial hydration (water).

RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death.

(Add additional pages if needed)

OTHER WISHES*: If you wish to write your own instructions, or you wish to add the instructions you have given above, you may do so here.*
I direct that:

(Add additional pages if needed)

PART 3: DESIGNATION OF PRIMARY PHYSICIAN(S)

I designate the following physician as my primary physician. If the first physician I designate below is not willing, able or reasonably available to act as my primary physician, I designate the following alternate physician as my primary physician:

_____	_____
(name of physician)	*(name of alternate physician)*
_____	_____
(street address)	*(street address)*
_____	_____
(city, state, zip)	*(city, state, zip)*
_____	_____
(phone number)	*(phone number)*

OTHER PROVISIONS: I revoke any prior Advance Healthcare Directive.

This Advance Healthcare Directive shall become effective upon my disability or incapacity, unless I have initialed the appropriate box in *Part 1*, in which case, my agent's authority becomes effective immediately.

EFFECT OF COPY: A copy of this form has the same effects as the original.

REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTHCARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising healthcare provider and any healthcare institution where I am receiving care and any others to whom I have given copies of this **power of attorney.** I understand that I may revoke the designation of an agent only by a signed writing or by personally informing the supervising healthcare provider.

SIGNATURE OF PRINCIPAL

Sign and date the form here

_____	_____
(your signature)	*(date)*
_____	_____
(print your name	*(your social security number-optional-verifies identity)*

_____

(street address) *(city)* *(state)* *(zip code)*

SIGNATURE OF WITNESSES

It is recommended, but not required, that you have two other individuals sign as witnesses

_____	_____
(signature of first witness) *(date)*	*(signature of second witness)* *(date)*
_____	_____
(print name of first witness)	*(print name of second witness)*
_____	_____
(address)	*(address)*
_____	_____
(city, state, zip)	*(city, state, zip)*