NEW MEXICO
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

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CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your New Mexico Advance Healthcare Directive

This packet contains a legal document, the New Mexico Advance Healthcare Directive that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part I, **Power of Attorney for Healthcare**, lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. Part II, **Instructions for Healthcare**, functions as your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself and:

a) you have an incurable or irreversible condition that will result in death within a relatively short time, or

b) you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or

c) the likely risks and burdens of treatment would outweigh the expected benefits.

Note: These documents will be legally binding only if the person completing them is a competent adult or an emancipated minor between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated.

Introduction to Your New Mexico Advance Healthcare Directive (continued)

How do I make my advance healthcare directive legal?

The law does not require that your advance directive be witnessed. However, witnesses are recommended to avoid concerns that this document might be forged, that you were forced to sign it, or that it does not genuinely represent your wishes.

Are there any important facts that I should know?

Section III of your New Mexico Advance healthcare Directive is an optional section that allows you to designate a physician to have primary responsibility for your healthcare.

A copy of your New Mexico Advance Healthcare Directive has the same effect as the original.

Completing Part I: Power of Attorney for Healthcare

Whom should I appoint as my agent?

A healthcare agent is the person you appoint to make decisions about your medical care if you become unable to make these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

The person you appoint as your agent cannot be an owner, operator or employee of a healthcare institution at which you receive care unless he or she is related to you by blood, marriage or adoption.

You can appoint a second and third person as your alternative agents. An alternative agent will step in if the person you name as agent is unable, unwilling or unavailable to act for you.

Note: If you appoint our spouse as your agent, the filing of a petition for or a decree of annulment, divorce, dissolution of marriage or legal separation revokes your spouse as your agent unless otherwise specified.

Should I add personal instructions to my Power of Attorney?

You can use the space provided under paragraph (2) to limit your agent's authority. Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you including:

a) consenting or refusing consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
b) selecting or discharging healthcare providers and institutions;
c) approving or disapproving diagnostic tests, surgical procedures, programs of medications and orders not to resuscitate; and
d) directing the provision, withholding and withdrawal of artificial nutrition and hydration and all other forms of healthcare.

One of the strongest reasons for naming a healthcare agent is to have someone who can respond flexibly as your medical condition changes and can deal with situations that you did not foresee. Talk with your healthcare agent about your future medical care and describe what you consider to be an acceptable "quality of life". If you want to record your wishes about specific treatments or conditions, you can use Part II of this document, Instructions for Healthcare.

Completing Part I: Power of Attorney for Healthcare (continued)

What if I change my mind?

If you wish to cancel your Power of Attorney for Healthcare you must personally notify your supervising healthcare provider, orally or in writing, of your intent to revoke.

Are there any important facts I should know?

Paragraphs (3) and (4) contain various statements about your agent's authority. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (5) nominates your agent or alternate agents to be your court-appointed guardian should one become necessary. If this is not your intention, cross out and initial this section.

Completing Part II: Instructions for Healthcare

Can I add personal instructions to my Instructions for Healthcare?

Yes. Paragraphs (6), (7) and (8) allow you to include instructions about certain care and treatment.

If there are any specific instructions that you would like to include that are not already listed on the document you may list them in paragraph (9).

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Instructions for Healthcare are to be decided by my agent."

What if I change my mind?

You may cancel your Instructions for Healthcare at any time in any manner that communicates your intent to do so.

INSTRUCTIONS

EXPLANATION

This form is optional. It lets you name someone else to make health care decisions for you if you become unable to make your own decisions and/or give instructions about your own health care. You may fill out some or all of this form. You may change all or any part of it, or use a different form.

If you have already signed a durable power of attorney for health care and/or a right to die statement (living will), they are still valid.

If you do fill out this form, be sure to sign and date it. You have the right to revoke (cancel) or replace this form at any time. Give copies of this signed form to your health care providers and institutions, health care agents you name, and your family and friends. A copy of this form has the same effect as the original.

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PART I
POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

(1) DESIGNATION OF AGENT: I appoint the following person as my agent to make health care decisions for me:

_ _
(name of agent)

_ _
(address)

_ _
(city) (state) (zip code)

_ _
(home phone) (work phone)

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PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR FIRST ALTERNATIVE AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATIVE AGENT

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

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If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health care decision for me, then I appoint the following person as my first alternative agents:

_ _
(name of first alternative agent)

_ _
(address)

_ _
(city) (state) (zip code)

_ _
(home phone) (work phone)

If I revoke the authority of my agent and the first alternative agent, or if neither is willing, able or reasonably available to make a health care decision for me, then I appoint the following person as my second alternative agent:

_ _
(name of second alternative agent)

_ _
(address)

_ _
(city) (state) (zip code)

_ _
(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me, and to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_ _

_ _

_ _

_ _

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health care professional determine that I am unable to make my own health care decisions. If I initial this box [ ], my agent's authority to make health care decisions for me takes place immediately and shall remain in effect despite my later incapacity.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4, OR 5 THAT DO NOT REFLECT YOUR WISHES

(4) AGENT'S RESPONSIBILITY: My agent shall make health care decisions for me based on this power of attorney for health care, and specific health care instructions I give and my other wishes to the extent known to my agent. If my wishes are unknown and cannot be determined, my agent shall make health care decisions for me based on my best interest. In determining my best interest, my agent shall consider my personal values to the extent known.

(5) NOMINATION OF GUARDIAN: I intend by this power of attorney for health care to avoid a court-supervised guardianship. If I need a guardian, I want my agent appointed in this form to be my guardian. If that agent cannot or will not act as my guardian, I want my alternative agents, in the order they are appointed in this form, to be my guardian.

PART II
INSTRUCTIONS FOR HEALTH CARE
"Living Will"

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 do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, 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 health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

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INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE -SUPPORT MEASURES

_____ I Choose NOT To Prolong Life: I do not want my life to be prolonged.

_____ I Choose To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

_____ I Choose To Let My Agent Decide: My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

INITIAL YOUR PREFERENCE REGARDING ARTIFICIAL NUTRITION AND HYDRATION

(7) ARTIFICIAL NUTRITION AND HYDRATION: I also specify that under the conditions mentioned in the above paragraph:

_____ I DO NOT want artificial nutrition and hydration provided to me in order to prolong my life.

_____ I DO want artificial nutrition and hydration provided to me in order to prolong my life.

_____ I DO NOT want artificial hydration unless required for my comfort.

_____ I DO want artificial hydration.

ADD PERSONAL INSTRUCTION ONLY IF YOU DISAGREE WITH THE STATEMENT IN PARAGRAPH (8)

(8) ANATOMICAL GIFT DESIGNATION: Upon my death, I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

_______ I CHOOSE to make an anatomical gift of all or my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

PRINT ANY ADDITIONAL INSTRUCTIONS THAT WILL GUIDE YOUR HEALTH CARE PROVIDER(S) AND AGENT

______ I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

____

______ I REFUSE to make an anatomical gift of my organs or tissue.

______ I CHOOSE to let my agent decide.

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(9) RELIEF FROM PAIN OR DISCOMFORT: 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 PERSONAL INSTRUCTION ONLY IF YOU DISAGREE WITH THE STATEMENT IN PARAGRAPH (9)

_ _

_ _

_ _

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

PRINT ANY ADDITIONAL INSTRUCTIONS THAT WILL GUIDE YOUR HEALTH CARE PROVIDER (S) AND AGENT

_ _

_ _

_ _

(add additional pages if needed)

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(OPTIONAL)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

PRINT YOUR NAME, ADDRESS, AND SOCIAL SECURITY NUMBER, AND THEN SIGN AND DATE THE DOCUMENT

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PART III
PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

____
(name of physician)

____
(address)

____
(city) (state) (zip code)

____
(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

____
(name of physician)

____
(address)

____
(city) (state) (zip code)

____
(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at anytime, and that if I revoke it, I should promptly notify my supervising health care provider and any health care 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 either by a signed writing or by personally informing the supervising health care provider.

PRINT YOUR NAME, ADDRESS, AND SOCIAL SECURITY NUMBER, AND THEN SIGN AND DATE THE DOCUMENT

SIGNATURES

____
(name)

____
(address)

____
(social security number - optional)

____
(signature)

____
(date)

These documents will be legally binding only if the person completing them is a competent adult or an emancipated minor between the ages of sixteen and eighteen who has been married, who is on active duty in the armed forces or who has been declared by court order to be emancipated.

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HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT, AND THEN PRINT THEIR NAMES AND ADDRESSES

Witnesses are recommended to avoid any concern that this document might be forged, that you were forced to sign it, or that it does not genuinely represent your wishes.

____
(signature of first witness) (date)

____
(printed name of first witness)

____
(address of first witness)

____

____
(signature of second witness) (date)

____
(printed name of second witness)

____
(address of second witness)

____

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Courtesy of Caring Connections
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You Have Filled Out Your Advance Directive, Now What?

1. Your New Mexico Advance Healthcare Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.

5. Remember, you can always revoke one or both sections of your New Mexico Advance Healthcare Directive.

6. Be aware that your New Mexico documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**