New Mexico Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

EXPLANATION: You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care 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 use this form, be sure to sign it and date it.

PART 1 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 2 of this form is a power of attorney for health care. PART 2 lets you name another individual as agent to make health-care 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 an alternate agent 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 health-care institution at which you are receiving care. Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to: (a) consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition; (b) select or discharge health-care providers and institutions; (c) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and (d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

Part 4 of this form lets you make choices regarding the donation of your organs after your death.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health-care directive or replace this form at any time.

Part 1: Living Will

If you are satisfied to allow your health care 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.

END OF LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and if:

(1) I have an incurable or irreversible condition that will result in my death within a relatively short time, **OR**

(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, **OR**

(3) 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 in one of the following three (3) boxes that:**

[ ] **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 Health Care Agent Decide**. My agent under my power of attorney for health care that I designate in this document may make life-sustaining treatment decisions for me.

If I have chosen above NOT to prolong life, I also specify by marking my initials below that:

[ ] I do NOT want artificial nutrition, **OR**

[ ] I DO want artificial nutrition.

[ ] I do NOT want artificial hydration unless required for my comfort, **OR**

[ ] I DO want artificial hydration.

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**. (State any additional directions if desired)**.

A copy of this form has the same effect as the original. I understand that I may revoke this Advance Health Care Directive at any time, 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.

Part 2: Selection of Health Care Agent (Power of Attorney for Health Care)

I designate the following individual as my agent to make health care decisions for me:
_____ (name), of
_____ (address).

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: 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, I designate as my first alternate agent
_____ (name of individual you choose as first alternate agent)
_____ (address)

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 **(State any limitations or exceptions. Add additional sheets if needed)**:

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 effect immediately.

AGENT'S OBLIGATIONS: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in this Advance Health Care Directive, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care 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 GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form.

Part 3: Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: 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)
_____ (address)
_____(phone).

Part 4: Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____