# NEW MEXICO
## Advance Directive
### Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:
- 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.

**BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, 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.

**ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

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

3. 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.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family,

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friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR NEW MEXICO ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, the **New Mexico Advance Health-Care 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.

**Part I, Power of Attorney for Health Care**, lets you name someone, called an "agent," to make decisions about your health care—including decisions about life support—if you can no longer speak for yourself. The power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own health-care decisions, not only at the end of life.

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

- you have an incurable or irreversible condition that will result in death within a relatively short time, or
- you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or
- the likely risks and burdens of treatment would outweigh the expected benefits.

Part II also allows you to record your organ donation, pain relief, and other advance planning wishes.

**Part III** allows you to designate a primary physician.

**Part IV** contains the signature and witnessing provisions so that your document will be effective.

You may complete Part I, Part II, Part III, or any or all parts, depending on your advance-planning needs. **You must complete Part IV.**

### How do I make my New Mexico Advance Health Care Directive legal?

You must sign and date this form after completing it. You are not required to have your document witnessed, but it may be helpful to do so in case your Advance Health-Care Directive is ever challenged.

**Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may 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 healthcare decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

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

**Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

**When does my agent's authority become effective?**

Part I, **Power of Attorney for Health Care** goes into effect when your doctor and one other qualified health professional determine that you no longer have the ability to understand and appreciate the nature and consequences of proposed healthcare and you are unable to make and communicate an informed healthcare decision. If you want your Power of Attorney for Health Care to go into effect immediately, you may select that option under Part I.

Part II, **Instructions for Health Care**, goes into effect when you have one of the listed conditions and your doctor determines that you are no longer able to make or communicate healthcare decisions.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

**Agent Limitations**

Your agent does **not** have the authority to consent to your admission to a mental healthcare facility, unless you expressly permit your agent to do so in your Advance Directive.

Your agent will be bound by the current laws of New Mexico as they regard pregnancy and termination of pregnancies.

**What if I change my mind?**

Except for the appointment of your agent, you may revoke any portion or your entire advance directive at any time and in any way that communicates your intent to revoke, so long as you have capacity. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either personally tell your supervising health-care provider of your intent to revoke or revoke your agent's appointment in a signed writing. If you are unable to sign and must have someone sign for you, your written revocation must be witnessed by two adults who sign in your presence, the presence of each other, and in the presence of the person signing for you.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in the "other wishes" section of Part II, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

**Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

**What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

EXPLANATION

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,________________________________________, (your name)
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)

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 alternate agent:

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

________________________________________
(name of first alternate agent)

________________________________________
(address)

________________________________________
(city) (state) (zip code)

________________________________________
(home phone) (work phone)

If I revoke the authority of my agent and the first alternate 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 alternate agent:

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

________________________________________
(name of second alternate agent)

________________________________________
(address)

________________________________________
(city) (state) (zip code)

________________________________________
(home phone) (work phone)

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

(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 ONLY 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 alternate agents, in the order they are appointed in this form, to be my guardian.

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

INITIAL YOUR PREFERENCES REGARDING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONLY ONE CHOICE FOR NUTRITION AND ONE CHOICE FOR HYDRATION

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## PART II: INSTRUCTIONS FOR HEALTH CARE

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:

_____ 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.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong live, 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.
OR
_____ I DO want artificial hydration.

(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:

INITIAL ONLY ONE CHOICE

_______ 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.

______ 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.

PRINT ANY ADDITIONAL INSTRUCTIONS THAT YOU WANT TO GUIDE YOUR HEALTH-CARE PROVIDER(S) AND AGENT

ADD PERSONAL INSTRUCTIONS ONLY IF YOU DISAGREE WITH THE STATEMENT IN PARAGRAPH (9)

(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:

____________________________________________________________

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH-CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(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:

_______________________________________________________________
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(add additional pages if needed)

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

## PART III: PRIMARY PHYSICIAN

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

______________________________
(name of physician)

______________________________
(address)

______________________________
(city) (state) (zip code)

______________________________
(phone)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR 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 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.

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## PART IV: EXECUTION

PRINT YOUR NAME AND ADDRESS AND THEN SIGN AND DATE THE DOCUMENT

Name ______________________________

Address ______________________________

______________________________

Signature ____________________ Date __________

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.

WITNESSES ARE OPTIONAL, BUT RECOMMENDED

**Witness No. 1**

Name ______________________________

Address ______________________________

______________________________

Signature ____________________ Date __________

**Witness No. 2**

Name ______________________________

Address ______________________________

______________________________

Signature ____________________ Date __________

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