

**New Mexico Advance Directive Form**

**(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)

If my agent cannot or will not make a health care decision for me, then I appoint these persons as my alternative agents, to serve in the following order:

\_\_\_\_\_

(name of first alternative agent)

\_\_\_\_\_

(address) (city) (state) (zip code)

\_\_\_\_\_

(home phone)

\_\_\_\_\_

(work phone)

\_\_\_\_\_

(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, except as I state here:

*(Add additional pages if needed)*

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

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

diagnostic tests, surgery, medication, hospitalization, nursing care, home health care, life-sustaining treatment including withholding or withdrawing life-sustaining treatment and the termination of life-support, the provision, withholding or withdrawal of artificial nutrition and hydration, all other forms of healthcare

(b) select or change health care providers and institutions.

**(3) AGENT'S RESPONSIBILITY:** My agent shall make health care decisions for me based on this durable power of attorney for health care, any 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.

**(4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician and one other qualified health care professional determines that I lack the capacity to make and communicate my own health care decisions.

**(5) DURABILITY:** This advance directive for health care, including but not limited to the power of attorney, shall remain in effect despite my later incapacity. This advance directive, including but not limited to the power of attorney, remains in effect from the date it was signed unless I revoke it or die.

**(6) END-OF-LIFE DECISIONS:** If I am unable to make or communicate decisions regarding my health care, and **IF:** (a.) I have an incurable and irreversible condition that will result in my death within a relatively short time; OR (b) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; OR (c) 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 choices I have initialed below by **one** of the following three choices:

**(a) 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.

OR

**(b) I choose NOT to prolong life:** I do not want my life to be prolonged. I understand that "NOT prolonging my life," means that I do not want any life support measures. OR

**(c) 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 Life", I also specify by marking my initials below:

**I DO** want artificial nutrition (food). OR

**I DO NOT** want artificial nutrition (food).

**I DO** want artificial hydration (water). OR

**I DO NOT** want artificial hydration (water).

**No matter which choices I have initialed in this section, I do want comfort care.**

**(8) 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)*

**(9) OTHER HEALTH CARE INSTRUCTIONS OR WISHES:** If you wish to write specific instructions about any aspect of your health care and medical treatment, including your end-of-life decisions, you may do so here. I direct that:

*(Add additional pages if needed)*

**(10) 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.

**(11) COPIES OF THIS FORM:** A copy of this form has the same effect as the original.

**(12) REVOCATION:** I may revoke my Health Care Instructions (Sections 6-9 of this form) in any way that shows my intent to do so. I may revoke the

appointment of an agent under my durable power of attorney for health care (Section 1 of this form) by a signed writing or by telling my doctor. If I revoke any or all of this form, I should promptly notify my doctor, my agent, any health care institution where I am receiving care and any others to whom I have given copies of this document.

**SIGN AND DATE BELOW:**

\_\_\_\_\_  
(your signature)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(optional social security number)

\_\_\_\_\_  
(address) (city) (state) (zip code)

***(This form does not have to be witnessed to be legally valid. 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)

\_\_\_\_\_  
(signature of second witness)

\_\_\_\_\_  
(print name of first witness)

\_\_\_\_\_  
(print name of second witness)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(address of first witness)

\_\_\_\_\_  
(address of second witness)

[This form complies with the provisions of the *New Mexico Uniform Care Decisions Act* of 1995, NMSA 1978 Sections 24-7A-18 (1997 Supp.)]