# New Mexico Living Will and Advance Healthcare Directive

*N.M. Stat. Ann. § 24-7A-4*

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

### POWER OF ATTORNEY FOR HEALTH CARE

(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me:

_____
(name of individual you choose as 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, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate agent)

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

_____
(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate 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:

(Add additional sheets if needed.)

(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 effect immediately.

(4) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any 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 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.

(5) **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. 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 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 in one of the following three boxes:

[_____] 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 life, I also specify by marking my initials below:

[_____] 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.

(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 sheets if needed.)

(9) **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 of 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.

(Add additional sheets if needed.)

[_____] I REFUSE to make an anatomical gift of any of my organs or tissue.

[_____] I CHOOSE to let my agent decide.

(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:

(Add additional sheets if needed.)

## PART 3

### 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 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.

(14) **SIGNATURES:** Sign and date the form here:

_____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city) (state) (zip code)

_____
(your social security number)

(Optional)

**SIGNATURES OF WITNESSES:**

First Witness:

_____
(date) (sign name)

_____
(print name)

_____
(address)

_____
(city) (state) (zip code)

Second Witness:

_____
(date) (sign name)

_____
(print name)

_____
(address)

_____
(city) (state) (zip code)

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