New Mexico Optional Advance Health Care Directive Form EXPLANATION FOR MEMBERS

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 is a power of attorney for health care. PART 1 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:

- 1. Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
- 2. Select or discharge health care providers and institutions;
- 3. Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
- 4. Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

PART 2 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 3 of this form lets you designate a physician to have primary responsibility for your health care.

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

(name of individual you choose as agent)						
(address)	(city)	(state)	(zip code)			
(home phone)	(w	(work phone)				
If I revoke my agent's authority or care decision for me, I designate as			ably available to make a he			
(name of i	ndividual you choose as	first alternate aş	gent)			
(address)	(city)	(state)	(zip code)			
(home phone)		(work phone)				
(name of i	ndividual you choose as	second alternate	e agent)			
(address)	(city)	(state)	(zip code)			
(home phone)	(W	(work phone)				
(2) AGENT'S AUTHORITY: My information about me and to make withhold or withdraw artificial nutrexcept as I state here:	all health care decisions	for me, including	ng decisions to provide,			
(Add additional sheets if needed.)						
(3) WHEN AGENT'S AUTHORIT when my primary physician and or make my own health care decisions care decisions for me takes effect in	ne other qualified health on s. If I initial this box [care professiona	al determine that I am unabl			

- (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

	(phone))	
(address)	(city)	(state)	(zip code)
	(name of physic	cian)	
(11) I designate the following	physician as my primary p	ohysician:	
	PART : PRIMARY PH		
(Add additional sheets if need	led.)		
		Tancer mar.	
(10) OTHER WISHES: (If y			u wish to add to the
[] I REFUSE to make an [] I CHOOSE to let my a	anatomical gift of any of nagent decide.	ny organs or ussue.	
I I DEFLICE to make an			
[] I CHOOSE to make a and artificial support may be			
[] I CHOOSE to make a suitability at the time of death removed.			
(9) ANATOMICAL GIFT DI to make an anatomical gift of			arked below whether I choose
	the best medical care possil	ble to keep me clean	rm and except as I state in the , comfortable and free of pain if this care hastens my death:
[] I DO want artificial hy	dration.		

	(name of physician)					
(address)	(city)	(state)	(zip code)			
		(phone)				
(12) EFFECT OF COP	Y: A copy of this form h	as the same effect as the o	original.			
DIRECTIVE at any tin provider and any health copies of this power of signed writing or by pe	ne, and that if I revoke it, a care institution where I attorney. I understand th	I should promptly notify am receiving care and any at I may revoke the design pervising health care proving the street of the st	DVANCE HEALTH CAR my supervising health care to others to whom I have given nation of an agent either by orider.			
(date)		(sign your name)				
(address)		(print your name)				
(city)	(state)	(your social security number)				
(Optional) SIGNATUR	ES OF WITNESSES:					
First witness:		Second witness:				
(print name)		(print name)				
(address)		(address)				
(city)	(state)	(city)	(state)			
(signature of witness)		(signatu	re of witness)			
(date)			(date)			

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