

Appendix—Forms

Form 1—Optional Advance Directive for Health Care

EXPLANATION OF POWER OF ATTORNEY FOR HEALTH CARE AND INSTRUCTIONS FOR HEALTH CARE AND END-OF-LIFE DECISIONS

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 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 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 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 the provisions, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. 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

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 which are 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:

- (a) I CHOOSE NOT To Prolong Life
I do not want my life to be prolonged.
- (b) 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.

(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:

(9) OTHER WISHES: (If you wish to write your own instructions for either

health care or end-of-life decisions, 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**

(10) 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)

(11) EFFECT OF COPY: A copy of this form has the same effect as the original unless the original has been revoked.

(12) 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 only by a signed writing or by personally informing the supervising health-care provider.

ALTERNATIVES TO GUARDIANSHIP AND CONSERVATORSHIP

(13) 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.

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

SIGNATURE OF PERSON GIVING POWER OF ATTORNEY:

Sign your name

Print your name

Date

Address (Street, City, State, Zip)

SIGNATURES OF WITNESSES: (Witnesses are not required by law, but are recommended.)

First witness:

Second witness:

Sign your name

Sign your name

Print your name

Print your name

Date

Date

Address

Address

Form 2—Acceptance of Appointment by Will**

Appendix-Forms

Court in and for _____ County, New Mexico, and the Seal of said Court, this _____ day
of _____, 19__.

CLERK OF THE DISTRICT COURT

By: _____
Deputy

(SEAL)

Date

Name
Address
City State Zip

Dear _____,

This letter will serve to advise you that according to the terms of the will of _____, deceased, I am named as your guardian. I intend to accept the nomination. I enclose for you a copy of _____'s Last Will and Testament which is being probated in the _____ District Court, PB No. _____.

Sincerely,

Name

Enclosure

Form 6—Sample Notice Letter from Guardian

Date

Name
Address
City State Zip

Re: Guardianship of the Person of _____, also known as

Ward's Birthdate:

Ward's Social Security Number:

Dear _____,

Please be advised that I have been appointed guardian of _____. I have enclosed a copy of the Letters of Guardianship for your files. Please contact me about any of _____'s health issues.

Sincerely,

Name
Address
City, State, Zip
Phone

Enclosure

Form 7—Sample Notice Letter from Conservator

Date

Name
Address
City State Zip

Re: Conservatorship of the Estate of _____, also known as

Conservatee's Birthdate:

Conservatee's Social Security Number:

Dear _____,

Please be advised that I have been appointed conservator of the estate of _____. Please have all future checks [this letter will vary, depending on what it is being used to do] made out to me _____, Conservator of the Estate of _____. I have enclosed a certified copy of the Letters of Conservatorship for your files. Please contact me about any of _____'s financial matters at the address listed on this letter.

Sincerely,

Name
Address
City, State, Zip
Phone

Enclosure