ALTA VISTA
Regional Hospital

Advance Directives & Medical Power of Attorney
Questions & Answers

1. **What is the Advance Directive/Medical Power of Attorney for?**
   Advance Directives is a way for you to state your wishes in a written form. If at some point in time you become unable to speak for yourself, to direct your medical care or last wishes, an *Advance Directive* can speak for you.
2. **Who should have an Advance Directive/Medical Power of Attorney?**
   An *Advance Directive* form should be filled out when you are healthy and have the time to think about what you wish to happen in the event that you are unable to speak for yourself, to direct your medical care. That can be done at anytime as long as you are able to communicate and are able to make your own decisions. At any time anyone can become sick or injured and not able to make their wishes known. We suggest that every person have advance directives.
3. **What can an Advance Directive/Medical Power of Attorney do?**
   Advance Directives covers a person's right to die, organ donation, feeding tubes, medications and surgery, CPR, use of ventilators and dialysis machines, living wills, funeral wishes, and medical power of attorney. It can also direct your wishes for specific donations you may want to make. Examples may include American Heart Association, or Hospice.
4. **What do I do after I have filled out an Advance Directive/Medical Power of Attorney?**
   Once the *Advance Directive* papers have been filled out to your satisfaction, think of someone you trust. Ask that person if they would be your advocate (your voice) to speak your wishes when you cannot. They would become your *Medical Power of Attorney*.
5. **Is this a legal document?**
   This form should be taken to a Notary to be notarized. This makes it legal. The notary is just to say that they witnessed your signature. The next step is to inform your family and close friends of your wishes concerning your health care choices and decisions.
6. **Who should have a copy of my Advance Directives/Medical Power of Attorney?**
   The person you trust to speak for you should have a copy of *your Advance Directives/Medical Power of Attorney* and also your physician. Each time you enter the hospital you should bring a copy with you, or have your trusted advocate bring their copy in. This way the hospital and your doctors are fully informed of your health care wishes.
7. **Can my Advance Directive or Medical Power of Attorney be changed?**
   Yes. You can change your *Medical Power of Attorney* at any time. It is your signature that must be notarized. Just make sure you inform your family, close friends, physicians and past *Medical Power of Attorney* of the change. Alta Vista Regional Hospital Notary's can only notarize *Medical Power of Attorney* that is part of the Advance Directives packet that can be obtained from the office of Admissions or Case Management. If a general Power of Attorney is needed it must be obtained and notarized by an attorney.

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HEALTH CARE DECISION MAKING FORMS

This packet contains the following forms:

1. New Mexico Living Will and Declaration under the Right to Die Act. This is a legal form in accordance with the New Mexico Right to Die Act. It allows you to state that you do not want maintenance medical treatment if you are ever certified as being terminally ill or in an irreversible coma. Your signature on the form must be witnessed by two people. This form does not need to be notarized.
2. New Mexico Durable Power of Attorney for Health Care Decisions – This is a legal form that allows you to authorize someone to make health care decisions on your behalf, if you become incapacitated. This form must be signed and notarized.
3. Values History Form – This form is designed to encourage discussion of your values, wishes and preferences so that someone else acting on your behalf will be able to make the decisions that you would have wanted. It is not a legal document, but you may with to attach it to your Living Will or Durable Power of Attorney.

NEW MEXICO LIVING WILL
AND
DECLARATION UNDER THE RIGHT TO DIE ACT

I, ____, being of sound mind and age 18 or older, willfully and voluntarily make my will and directive that my life shall not be prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should be certified in writing by two physicians, one of whom is in charge of my care, to have a terminal illness or be in an irreversible coma, I direct that maintenance medical treatment be withheld or withdrawn, and that I be permitted to die.
2. By maintenance medical treatment, I mean any medical treatment that is designed solely to sustain the life process, but I do not mean medication administration for the purpose of easing pain and discomfort.
3. In the absence of my ability to give directions regarding the use of maintenance medical treatment, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical treatment, and I accept the consequences of such refusal.
4. If my attending physician declines to participate in the withholding or withdrawal of a maintenance medical treatment, he/she must take steps to transfer me to another physician who will honor my wishes.
5. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.
6. I understand that I may revoke this directive at any time by destroying it or saying so in the presence of someone over the age of 18.
7. I will keep the original of this document at:

   ____
   (Name the place or person who will have the original document)

   I will give copies of this document to:
   ____

   ____
   (Name the place or person who will have copies of the document)

8. If there are any uncertainties or ambiguities about this directive, of the treatment that I should be given if I become incompetent, I request my physician to discuss the matter with ____, who know my interests and values, and with whom I have discussed my wishes.

9. I offer this further expression of my wishes: (optional)

____

____

____

__________ (your initials)

______________________________ ______________________________
Date Signature

____
Address

This form must be witnessed below:

WITNESSES

We believe the person who signed this document to be of sound mind and under no constraint or undue influence. We are not related to him/her by blood or marriage; nor would we be entitled to or have any claim against any portion of his/her estate upon death; nor are we his/her attending physicians or any employee of the attending physicians or a health care facility in which he/she is a patient; nor are we patients in the health care facility in which he/she is a patient; nor are we responsible for his/her care costs.

On this ______________day of ______________, 20 _____, the person who signed this document, ______________________________, or ____________________________(street address), ______________________________ (city), New Mexico, signed the foregoing document, consisting of two typewritten pages, in our sight and presence and declared the same to be his/her document under the Right to Die Act, and at his/her request in his/her sight and presence, and in the sight and presence of each other, we signed our names as witnesses.

______________________________ ______________________________
Witness Address
____

______________________________ ______________________________
Witness Address
____

NEW MEXICO DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

The powers granted by this document are broad and sweeping. The document is prepared in accordance with NMSA 1978, s45-5-502, and should be interpreted consistently with that statute.

I, ______________________________________, reside in ________________________ County, New Mexico. I appoint ____ (Names(s)) to serve as my legally-authorized decision maker(s). If any decision maker appointed above is unable to serve, then I appoint ___________________________(Name) to serve as my decision maker in place of the person who is unable to serve.

*Check and initial the following paragraph only if one person is appointed on your behalf and you want any one of them to have the power to act alone without the signature of the other(s). If you do not check and initial the following paragraph, and more than one person is named to act on your behalf, then they must act jointly.

( ) _____________ If more than one person is appointed to serve as my decision maker, then each may act alone and independently of each other.

My decision maker shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

Initial the space opposite each authorization which you desire to give to your decision maker. Your decision maker shall be authorized to engage only in those activities which are initialed. Cross out those authorizations you do not desire to give your decision maker.

_____ 1. Decisions regarding lifesaving/life prolonging medical treatment.

_____ 2. Decisions relating to medical treatment, surgical treatment, nursing care, medication, and hospitalization.

_____ 3. Decisions relating to residence in a nursing home or other facility and home health care.

_____ 4. Transfer of property or income as a gift to my spouse for the purpose of qualifying me for governmental medical assistance (i.e., giving my property to my spouse so I will qualify for Medicaid).

____ 5. List others related to health care: ____

This power of attorney shall become effective only if I become incapacitated and shall terminate upon my death, unless I have revoked it prior to my death. By incapacity, I mean that, among other things, I am unable to effectively make or communicate health or personal care decisions.

____
Signature

Dated: ________________________________, 20 ______

This form must be notarized below.

ACKNOWLEDGEMENT

STATE OF NEW MEXICO)
) ss
COUNTY OF __________)

The foregoing instrument was acknowledged before me this ______________day of ________________ 20 _____, by ____.

____
Notary Public

My commission expires:

____

VALUES HISTORY FORM: SUGGESTIONS FOR USE

Here, as you requested, is the Values History Form developed at the Center for Health, Law, and Ethics, University of New Mexico School of Law. The form is not a legal document, although it may be used to supplement a Living Will or a Durable Power of Attorney for Health Care, if you have these. Also, the Values History Form is not copyrighted, and you are encouraged to make additional copies for friends and relatives to use.

WHY A VALUES HISTORY FORM?

The Values History Form, especially pages 2-6, recognizes that the medical decisions we make for ourselves are based on those beliefs, preferences, and values that matter most to us: How do we feel about independence and control? About pain, illness, dying and death: What in life gives us pleasure? Sorrow? A discussion of these and other values can provide important information for those who might, in the future, have to make medical decisions for us when we are no longer able to do so.

Further, a discussion of the questions asked for the Values History Form can provide a solid basis for families, friends, physicians, and others when making such medical decisions. By talking about such issues ahead of time, family disagreements may be minimized. And when such decisions need to be made, the burden of responsibility may be lessened because others feel confident of your wishes.

HOW DO I FILL OUT THE VALUES HISTORY FORM?

Section 1 (pages 1-2) allows you to record both written and oral instructions you might already have prepared. Simply answer the questions. If you have not yet written or talked about these issues, you might wait to complete this section at a later date, perhaps after you have completed Section 2.

Section 2 asks a number of questions about issues, such as: your attitude toward your health; your feelings about your health care providers; your thoughts about independence and control; personal relationships; your overall attitude toward life; your attitude toward illness/dying/death; your religious background and beliefs; your living environment; your attitude toward finances; your wishes concerning your funeral.

There are a number of ways in which you might begin to answer these questions. Perhaps you would like to write out some of your thoughts before you talk with anyone else. Or you might ask family and friends to come together and talk about your – and their – responses to the questions.

Often simply making copies of the Values History Form available to others is enough to get people talking about a subject that, for many of us, is difficult and painful to consider. The most important thing to remember is that it is easier to talk about theses issues **BEFORE** a medical crisis occurs. Feel free to add questions and comments of your own to those already provided.

WHAT SHOULD I DO WITH MY COMPLETED VALUES HISTORY FORM?

Make certain that all those who might be involved in future medical decisions made on your behalf are aware of your wishes: family, friends, physicians, and other health care providers, your lawyer, our pastor. If appropriate, provide written copies to these people. But remember that each of us continues to grow and change, and so the Values History Form should be discussed and updated fairly regularly, as preferences and values evolve. Consider attaching a copy of it to your Living Will or Durable Power of Attorney for Health Care, if you have one, or filing the Values History Form with your important medical papers.

WHAT IF I DO NOT HAVE A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Whether you sign either of these is entirely up to you, and laws governing these vary from state to state. For information and assistance, the following agencies might be of help:

CONCERN FOR DYING/SOCIETY FOR THE RIGHT TO DIE
250 West 57 Street, New York, NY 10107
(212)246-6973

This agency will provide legal information about Living Wills and Durable Power of Attorney for Health Care, as applicable to your own state. Please write to them at the above address. Because of the recent large volume of requests, expect a 4-6 weeks turn-around time. If you have an emergency, you may telephone them, but they caution that it is very difficult to get through on the telephone.

AMERICAN ASSOCIATION OF RETIRED PERSONS

For a single, free copy of the Health care Power of Attorney booklet, please sent a postcard with your name and address to:

AARP Fulfillment
Stock No. D13895
1909 K. Street, N.W.
Washington, D.C. 20049

You might also contact your local Office of Senior Affairs, your State of Area Agency on Aging, agencies providing Legal Services for the Elderly, or your personal attorney.

WHO SHOULD CONSIDER PREPARING A VALUES HISTORY FORM?

Everyone. While it has been customary to focus on older people, it is just as important that younger people discuss these issues and make their wishes known. Often some of the most difficult medical decisions must be made on behalf of these younger patients. If they had talked with families and friends, these decision makers could feel reassured they were following the patient’s wishes.

We hope this Values History Form is of help to you, your families, and friends. Many people have commented that it is important to reflect not so much on “How I want to die,” but rather on “How I want to LIVE until I die.”

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VALUES HISTORY FORM

NAME: ____

DATE: ____

If someone assisted you in completing this form, please fill in their name, address, and relationship to you.

NAME: ____

ADDRESS: ____
____

RELATIONSHIP: ____

The purpose of this form is to assist you in thinking about and writing down what is important to you about your health. If you should at some time become unable to make health care decisions for yourself, your thoughts as expressed on this form may help others make a decision for you in accordance with what you would have chosen.

The first section of this form asks whether you have already expressed your wishes concerning medical treatment through written or oral communications and if not, whether you would like to do so now. The second section of this form provides an opportunity for you to discuss your values, wishes, and preferences in a number of different areas, such as your personal relationships, your overall attitude toward life, and your thoughts about illness.

This form is not copyrighted; you may make as many copies as you wish.

SECTION 1

A. WRITTEN LEGAL DOCUMENTS

Have you written any of the following documents? If so, please complete the requested information.

LIVING WILL

Date written: ____________________

Document location: _______________

Comments: (e.g., any limitations, special requests, etc.) _____________

____

____

____

DURABLE POWER OF ATTORNEY

Date written: ____________________

Document location: _______________

Comments: (e.g., whom have you named to be your decision maker?)

____

____

____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Date written: ____________________

Document location: _______________

Comments: (e.g., whom have you named to be your decision maker?)

____

____

____

ORGAN DONATIONS

Date written: ____________________

Document location: _______________

Comments: (e.g., any limitations on which organs you would like to donate?) _______________________

____

____

____

B. WISHES CONCERNING SPECIFIC MEDICAL PROCEDURES

If you have ever expressed your wishes, either written or orally, concerning any of the following procedures, please complete the requested information. If you have not previously indicated your wishes on these procedures and would like to do so now, please complete this information.

ORGAN DONATION

To whom expressed: ______________

If oral, when? ____________________

If written, when? _________________

Document location: _______________

____

Comments: _____________________

____

____

KIDNEY DIALYSIS

To whom expressed: ______________

If oral, when? ____________________

If written, when? _________________

____

Comments: _____________________

____

____

CARDIOPULMONARY RESUSCITATION (CPR)

To whom expressed: ______________

If oral, when? ____________________

If written, when? _________________

Document location: _______________

____

Comments: _____________________

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RESPIRATORS
To whom expressed: _______________
If oral, when? ______________________
If written, when? __________________
Document location: ________________
____
Comments: _______________________
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ARTIFICIAL NUTRITION
To whom expressed: _______________
If oral, when? ______________________
Document location: ________________
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Comments: _______________________
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____

ARTIFICIAL HYDRATION
To whom expressed: _______________
If oral, when? ______________________
If written, when? __________________
Document location: ________________
____
Comments: _______________________
____
____

C. GENERAL COMMENTS
Do you wish to make any general comments about the information you provided in this section? ____________
____
____
____

SECTION 2
A. YOUR OVERALL ATTITUDE TOWARD YOUR HEALTH
1. How would you describe your current health status? If you currently have any medical problems, how would you describe them?
____
____
____

2. If you have current medical problems, in what ways, if any, do they affect you ability to function? ___
____
____
____

3. How do you feel about your current health status? _____________________
____
____

4. How well are you able to meet the basic necessities of life: eating, sleeping, food preparation, personal hygiene, etc? ______________________
____
____

5. Do you wish to make any general comments about your overall health?
____
____
____

B. YOUR PERCEPTION OF THE ROLE OF YOUR DOCTOR AND OTHER HEALTHCARE PROVIDERS
1. Do you like your doctors? ________
____

2. Do you trust your doctors? _______
____

3. Do you think your doctors should make the final decision concerning any treatments you might need? _____
____

4. How do you relate to your caregivers, including nurses, therapists, chaplains, social workers, etc.? ______________________________
____
____
____

C. YOUR THOUGHTS ABOUT INDEPENDENCE AND CONTROL

1. How important is independence and self-sufficiency in your life? ____
____
____

2. If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency? ________________
____
____

3. Do you wish to make any general comments about the value of independence and control in your life?
____
____
____

D. YOUR PERSONAL RELATIONSHIPS

1. Do you expect that your friends and/or others will support your decisions regarding medical treatment you may need now or in the future? ______________________
____
____

2. Have you made any arrangements for your family/friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances? ________________
____
____

3. What, if any, unfinished business from the past, are you concerned about (e.g., personal and family relationships, legal and business matters)? ______________________
____
____
____

4. What role do your friends and family play in your life? ___________
____
____

5. Do you wish to make any general comments about the personal relationships in your life? __________
____
____

E. YOUR OVERALL ATTITUDE TOWARD LIFE

1. What activities do you enjoy (e.g., hobbies, watching TV, etc.)? _______
____
____

2. Are you happy to be alive? ______
____
____

3. Do you fell that life is worth living?
____
____

4. How satisfied are you with what you have achieved in your life? _____
____

5. What makes you laugh/cry? _____
____

6. What frightens or upsets you? What do you fear most? __________
____
____

7. What goals do you have for the future? ______________________
____
____
____

8. Do you wish to make any general comments about your attitude toward life? ______________________________
____
____

F. YOUR ATTITUDE TOWARD ILLNESS, DYING, AND DEATH

1. What will be important to you when you are dying (e.g., physical comfort, spiritual support, no pain, family members present, etc.)? ____________
____
____

2. Where do you prefer to die? ______
____

3. What is your attitude toward death? ____________________________
____

4. How do you feel about the use of life sustaining measures in the face of: Terminal illness? _______________
____
Permanent coma? _________________
____
Irreversible chronic illness (e.g. Alzheimer's disease)? ______________
____

G. YOUR RELIGIOUS BACKGROUND AND BELIEFS

1. What is your religious background? ______________________

2. How do your religious beliefs affect your attitude toward serious or terminal illness? ___________________
____
____

3. Does your attitude toward death find support in your religion? ________
____
____

4. How does your faith community, church or synagogue view the role of prayer or religious sacraments in an illness? ____________________________
____

5. Do you wish to make any general comments about your religious background and beliefs? ____________
____

H. YOUR LIVING ENVIRONMENT

1. What has been your living situation over the past 10 years (e.g., lived alone, lived with others, etc.)? _______
____

2. How difficult is it for you to maintain the kind of environment for yourself that you find comfortable? Does any illness or medical problem you have now mean that it will be harder in the future? _______________
____
____

3. Do you wish to make any general comments about your living environment? ______________________
____
____

I. YOUR ATTITUDE CONCERNING FINANCES

1. How much do you worry about having enough money to provide for your care? ________________________
____
____

2. Would you prefer to spend less money on your care so that more money can be saved for the benefit of your relatives and/or friends? _______
____
____
____

3. Do you wish to make any general comments concerning your finances and the cost of healthcare? _________
____
____

J. YOUR WISHES CONCERNING YOUR FUNERAL

1. What are your wishes concerning your funeral and burial or cremation?
____
____

2. Have you made your funeral arrangements? If so, with whom? ____
____
____

3, Do you wish to make any general comments about how you would like your funeral and burial or cremation to be arranged or conducted? _________
____
____

OPTIONAL QUESTIONS

1. How would you like your obituary (announcement of your death) to read? __________________________
____
____
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2. Write yourself a brief eulogy (a statement about yourself to be read at your funeral). ____________________
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SUGGESTIONS FOR USE: After you have completed this form, you may wish to provide copies to your doctors and other healthcare providers, your family, your friends, and your attorney. If you have a Living Will or Durable Power of Attorney for Health Care Decisions, you may wish to attach a copy of this form to those documents.

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PATIENT SELF-DETERMINATION POLICY

STATEMENT OF RECEIPT

I, ____, hereby certify that I have been provided with a Patient Self-Determination Packet in accordance with the Patient Self-Determination Policy, which explains my individual rights under the laws of the State of New Mexico, to make decisions about my medical care, including my right to accept or refuse treatment, and my right to formulate advance directives.

____ _________________________

Signature of Patient Date

____ _________________________

Signature of Patient Date

ACKNOWLEDGEMENT OF ADVANCE DIRECTIVES

I, ____, already have an advance directive: YES _______NO_______ (check one). My advance directive takes the form of a: Living Will _______, Durable Power of Attorney for Health Care _______ (check one or both). I am hereby delivering a copy of my advance directive(s) to the hospital: YES ____NO____ (check one). If no, I intend to delivery a copy of my advance directive(s) to the hospital as soon as possible: YES _____NO_____ (check one). I hereby certify that I understand it is my sole responsibility to inform the hospital that I have an advance directive(s) and to deliver such advance directive(s) to the hospital.

____ _________________________

Signature Date