Triage Health Estate Planning Toolkit: New Mexico

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

New Mexico probate courts accept written and statutory wills. To make a valid written will in New Mexico:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old (or an emancipated minor)
    - Of "sound mind" (meaning you know what you're doing)
    - Free from coercion or outside pressure
2. You need to sign the will, or direct someone to do so for you in your presence, in front of two witnesses.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

New Mexico allows for remote notarization. Check with your state's laws to confirm that remote notarization of a will is allowed at the time you want to execute your will. The New Mexico state legislature created a statutory will form to make this process easier and more accessible. With this free will form, you can execute your will by filling in the blanks and signing it in front of two witnesses (who meet the same requirements for a written will).

The benefits of this statutory will are that it is free to complete, and you can complete it on your own, without hiring an attorney. The downsides of a statutory will are that they cannot be customized. Therefore, statutory wills are best for very simple estates. Part III of this toolkit includes a sample form.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In New Mexico, a statutory power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In New Mexico, this form contains four parts.

1. **Power of Attorney for Health Care:** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, if you become unable. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care, unless you indicate you want it to go into effect immediately after you sign it. Unless they are related to you, your agent cannot be an owner, operator, or employee of a health care institution where you are receiving care.

2. **Instructions for Health Care:** Sometimes called a "living will," this document lets you indicate your preferences for end-of-life health care if you develop an incurable, terminal condition, or you become unconscious. You can provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include. You can also indicate whether or not you would like to make an organ or tissue donation.

3. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care.

4. **Signature and Witnessing Provisions:** This is where you sign and date your advance health care directive to make it legal. Witnesses are recommended, but not required. Your witnesses should be at least 18 years old, and should not be your health care representative or alternate representative.

To revoke your agent's appointment, tell your supervising health care provider of your decision, or tell them with a signed, written statement. You can revoke any other portion of your advance health care directive at any time, in any way that shows your desire to do so (e.g., telling your primary physician or destroying the document).

If you appoint your spouse as your representative, this will be automatically revoked if your marriage dissolves, unless you specify differently in the "other wishes" section.

Part III of this toolkit includes a sample advance health care directive.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In New Mexico, this form is called a medical order for scope of treatment (MOST). The MOST does not replace an advance directive. You can complete a MOST form with your doctor. This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted hydration and nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III includes a sample form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

New Mexico has a **Pre-Death Cremation Authorization** form, which allows you to authorize your remains to be cremated after your death. You can also include instructions for what you would like to happen to your cremated remains (e.g., distributed among family members or in a special location). If you would like to appoint someone to oversee the disposal of your remains or your funeral arrangements, New Mexico law requires you to do this through your will.

Part III includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

On June 18, 2021, the Elizabeth Whitefield End of Life Options Act went into effect in New Mexico. This allows adults with terminal illnesses to voluntarily request medication that would hasten death from their physicians. Qualified patients must:

- Be 18 years or older
- A resident of New Mexico
- Terminally ill, with a prognosis of six months or less to live
- Be capable of making your own health care decisions
- Be acting voluntarily
- Be capable of self-administering the medication

If you would like to request aid-in-dying medication, start by talking to your physician. The conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation you must:

- In most cases, have a confirmed terminal illness by two doctors. Only one doctor is needed if the individual is in hospice.
- Receive information from your provider on all of your end-of-life care options, including hospice and pain symptom management
- Complete the "Request to End My Life in a Peaceful Manner" form and present it to your provider
- Wait 48 hours until the prescription can be filled

If your provider is unwilling to prescribe the medication, your provider must either refer you to a participating provider or to an individual or entity who can help you carry out your request.

The law specifies that taking the aid-in-dying medication is not suicide and your underlying illness should be listed as your cause of death.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

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Part III: Your State's Estate Planning Forms

- Statutory Will
- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Scope of Treatment (MOST)
- Pre-Death Cremation Authorization
- HIPAA Authorization Form

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Statutory Will

45-2A-17. Form of statutory will.

I, _____, of the City of _____, County of _____, and State of _____, declare this to be my Last Will and hereby revoke all of my prior wills and codicils.

1. I direct that my testamentary estate be disposed of in accordance with the Uniform Statutory Will Act [45-2A-1 to 45-2A-17 NMSA 1978], as in effect on the date of execution of this will.

2. I appoint _____ as personal representative of my estate under this will. If a trust becomes applicable under the provision of the Act, I appoint _____ as trustee hereunder. If either of them does not serve, or at any time ceases to serve, in either capacity, I appoint _____ to serve in the vacant capacity or capacities. I appoint _____ as guardian and conservator of my minor children. I, _____, the testator, sign my name to this instrument this _____ day of _____, 19 ____, and being first duly sworn, do hereby declare to the undersigned authority that I sign and execute this instrument as my Last Will and that I (sign it willingly) (willingly direct another to sign for me) (cross out the one of these two alternatives that is inapplicable), that I execute one of these two alternatives that is inapplicable, that I execute it as my free and voluntary act for the purpose therein expressed, and that I am 18 years of age or older, of sound mind, and under no constraint or undue influence.

_____

Testator

We, _____ and _____ the witnesses, sign our names to this instrument, being first duly sworn, and do hereby declare to the undersigned authority that the testator signs and executes this instrument as (his) (her) Last Will and that (he) (she) (signs it willingly) (willingly directs another to sign) (her) (him) (cross out the inapplicable word or phrase in each of these instances), and that each of us, in the presence and hearing of the testator, hereby signs this will as witness to the testator's signing, and that to the best of our knowledge the testator is 18 years of age or older, of sound mind, and under no constraint or undue influence.

_____

Witness

_____

Witness

State of _____

County of _____

Subscribed, sworn to and acknowledged before me by _____, the testator, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 19 ____.

(Seal)

(Signed)

_____

_____

_____

(official capacity of officer)

History: Laws 1991, ch. 173, § 17.

Effective dates. - Laws 1991, ch. 173 contains no effective date provision, but, pursuant to N.M. Const., art. IV, § 23, is effective on June 14, 1991.

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Power of Attorney for Financial Affairs

New Mexico Statutory Power of Attorney

NOTICE: THIS IS AN IMPORTANT DOCUMENT. THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT, CHAPTER 45, ARTICLE 5, PART 6 NMSA 1978. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, YOU SHOULD ASK A LAWYER TO EXPLAIN THEM TO YOU. THIS FORM DOES NOT PROHIBIT THE USE OF ANY OTHER FORM. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I, _____ (Name) reside at _____, (Address) New Mexico.

I appoint _____ (Name(s) and address(es)) to serve as my attorney(s)-in-fact.

If any attorney-in-fact appointed above is unable to serve, then I appoint _____ to serve as successor attorney-in-fact in place of the person who is unable to serve.

This power of attorney shall not be affected by my incapacity but will terminate upon my death unless I have revoked it prior to my death. I intend by this power of attorney to avoid a court-supervised guardianship or conservatorship.

Should my attempt be defeated, I ask that my agent be appointed as guardian or conservator of my person or estate.

STRIKE THROUGH THE SENTENCE ABOVE IF YOU DO NOT WANT TO NOMINATE YOUR AGENT AS YOUR GUARDIAN OR CONSERVATOR.

CHECK AND INITIAL THE FOLLOWING PARAGRAPH ONLY IF YOU WANT YOUR ATTORNEY(S)-IN-FACT TO BE ABLE TO ACT ALONE AND INDEPENDENTLY OF EACH OTHER. 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 attorney-in-fact then they may act severally, alone and independently of each other.

My attorney(s)-in-fact 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 IN THE BOX IN FRONT OF EACH AUTHORIZATION WHICH YOU DESIRE TO GIVE TO YOUR ATTORNEY(S)-IN-FACT. YOUR ATTORNEY(S)-IN-FACT SHALL BE AUTHORIZED TO ENGAGE ONLY IN THOSE ACTIVITIES WHICH ARE INITIALED.

INITIAL

(____) 1. real estate transactions.

(____) 2. stock and bond transactions.

(____) 3. commodity and option transactions.
(____) 4. tangible personal property transactions.
(____) 5. banking and other financial institution transactions.
(____) 6. business operating transactions.
(____) 7. insurance and annuity transactions.
(____) 8. estate, trust and other beneficiary transactions.
(____) 9. claims and litigation.
(____) 10. personal and family maintenance.
(____) 11. benefits from Social Security, Medicare, Medicaid or other government programs or civil or military service.
(____) 12. retirement plan transactions.
(____) 13. tax matters, including any transactions with the Internal Revenue Service.
(____) 14. decisions regarding lifesaving and life prolonging medical treatment.
(____) 15. decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, institutionalization in a nursing home or other facility and home health care.
(____) 16. transfer of property or income as a gift to the principal's spouse for the purpose of qualifying the principal for governmental medical assistance.
(____) 17. ALL OF THE ABOVE POWERS, INCLUDING FINANCIAL AND HEALTH CARE DECISIONS. IF YOU INITIAL THE BOX IN FRONT OF LINE 17, YOU NEED NOT INITIAL ANY OTHER LINES.

SPECIAL INSTRUCTIONS: ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS YOU HAVE GRANTED TO YOUR AGENT.

_____
_____
_____
_____
_____
_____
_____
_____

CHECK AND INITIAL THE FOLLOWING PARAGRAPH IF YOU INTEND FOR THIS POWER OF ATTORNEY TO BECOME EFFECTIVE ONLY IF YOU BECOME INCAPACITATED. YOUR FAILURE TO DO SO WILL MEAN THAT YOUR ATTORNEY(S)-IN-FACT ARE EMPOWERED TO ACT ON YOUR BEHALF FROM THE TIME YOU SIGN THIS DOCUMENT UNTIL YOUR DEATH UNLESS YOU REVOKE THE POWER BEFORE YOUR DEATH.

( ) _____ This power of attorney shall become effective only if I become incapacitated. My attorney(s)-in-fact shall be entitled to rely on notarized statements from two qualified health care professionals, one of whom shall be a physician, as to my incapacity. By incapacity I mean that

among other things, I am unable to effectively manage my personal care, property or financial affairs.

This power of attorney will not be affected by lapse of time. I agree that any third party who receives a copy of this power of attorney may act under it.

_____
(Signature)

_____
(Optional, but preferred: Your social security number)
Dated: _____, 20_____

ACKNOWLEDGEMENT

NOTICE: IF THIS POWER OF ATTORNEY AFFECTS REAL ESTATE, IT MUST BE RECORDED IN THE OFFICE OF THE COUNTY CLERK IN EACH COUNTY WHERE THE REAL ESTATE IS LOCATED.

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)

The foregoing instrument was acknowledged before me on _____, 20___, by _____

_____.
Notary Public
My Commission Expires: _____

(seal)

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

24-7A-4. Optional form.

OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE
Explanation

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:

(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;
(b) approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
(c) direct the provision, withholding or withdrawal of artificial nutrition and hydration m 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

(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 healthcare 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:

_____

_____

(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.

_____

_____

[ ] 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 healthcare provider.

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

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____ _____

(city) (state) (your social security number)

(Optional) SIGNATURES OF WITNESSES:

First witness Second witness

_____ _____

(print your name) (print your name)

_____ _____

(address) (address)

_____ _____

(city) (state) (city) (state)

_____ _____

(signature of witness) (signature of witness)

_____ _____

(date) (date)

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Physician Orders for Life Sustaining Treatment (POLST)

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

This medical order is consistent with the patient's wishes and should be considered in the same manner as a DNR order issued prior to a hospitalization. The New Mexico MOST is an advance healthcare directive or healthcare decision and must be honored in accordance with state law (NMSA 1978§24-7A-1 et seq.) If there is a conflict between this directive and an earlier directive, the most current choices made by the patient or the Healthcare Decision Maker shall control.

New Mexico Medical Orders For Scope of Treatment (MOST)

First follow these orders, **then** contact the healthcare provider. These medical orders are based on the person's **current** medical condition and preferences. Any section not completed does not invalidate the form.

Last Name/First/Middle Initial

Address

City/State/Zip

Date of Birth (mm/dd/yyyy)

A — EMERGENCY RESPONSE SECTION: Person has no pulse or is not breathing.

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

When not in Cardiopulmonary arrest, follow orders in **B, C** and **D.**

B — MEDICAL INTERVENTIONS: Patient has a pulse

Check One

☐ **Comfort Measures: Do not transfer to hospital unless comfort needs cannot be met in current location.** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.

☐ **Limited Additional Interventions:** May include care as described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid Intensive Care.**

☐ **All Indicated Interventions:** May include care as described above. **Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes Intensive Care.**

Additional Orders:

C — ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

Check One

(Always offer food and liquids by mouth if feasible and desired.)

☐ No artificial nutrition. ☐ No artificial hydration.

☐ Time-limited trial of artificial nutrition. ☐ Time-limited trial of artificial hydration.

Goal of the trial: _____

☐ Long-term artificial nutrition/hydration.

D

Discussed with: ☐ Patient ☐ Healthcare Decision Maker ☐ Parent of Minor ☐ Court Appointed Guardian ☐ Other ☐ Interpreter used

Signature of Authorized Healthcare Provider: My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences. Authorized Providers include: Medical Doctor, Doctor of Osteopathic Medicine, Advance Practice Nurse and Physician Assistant.

Authorized Healthcare Provider Name (required, please print)	Authorized Healthcare Provider Phone Number
Authorized Healthcare Provider Signature (required)	Date

Signature of Patient or Healthcare Decision Maker: By signing this form, I declare I have had a conversation with the healthcare provider. I direct the healthcare provider and others involved in care to provide healthcare as described in this directive. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing must be the legal surrogate.

Signature (required)	Name (print)	Date
Address	Phone	Relationship to the Patient

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

For easy identification, please print on "Wausuau Astrobright Terra Green" 65 lb paper. However, white photocopies, faxes and electronic scans are valid.

	Last Name/First/Middle Initial
	Address
	City/State/Zip
	Date of Birth (mm/dd/yyyy)

DESIGNATION OF HEALTHCARE DECISION MAKER

(This designation can be completed only by a patient with decisional capacity)

The Designation of Healthcare Decision Maker is an advance healthcare directive and must be honored in accordance with state law (NMSA 1978§24-7A-1 et seq.) If there is a conflict between this directive and an earlier directive, the most current choice(s) made by the patient shall control.

If the time comes when I lack capacity and there are medical decisions that need to be made that are beyond the individual instructions as set forth in this MOST, I designate the following individual as my agent to make healthcare decisions for me:	
Name:	
Address:	
Telephone Number:	
Signature of Patient:	Date:
If my agent listed above is not willing, able or available to make healthcare decisions for me, I designate the following individual as my alternate agent for the purposes of making healthcare decisions for me:	
Name:	
Address:	
Telephone Number:	
Signature of Patient:	Date:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Directions for Healthcare Professional

Completing MOST

- Must be completed by healthcare professional based on patient preferences and medical indications.
- Choice of Medical Intervention and Cardiopulmonary Resuscitation status must be clinically aligned:
- Example: "Comfort Care" and "Attempt Resuscitation" are contradictory choices.
- MOST must be signed by an authorized healthcare provider and the patient/decision maker to be valid. Verbal orders are acceptable with follow-up signature by the authorized healthcare provider in accordance with facility/community policy.
- Use of the original form is strongly encouraged. Photocopies and faxes of signed MOST forms are legal and valid.
- Authorized Provider is defined and updated in the Department of Health, Emergency Medical Services Regulation—Chapter 27.

Using MOST

- A person with capacity, or the Healthcare Decision Maker of a person without capacity, can request alternative treatment.

Reviewing MOST

It is recommended that the MOST be reviewed periodically. Review is recommended when

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Funeral Designation Form

State of New Mexico

Pre-death Cremation Authorization*

as authorized by New Mexico statute 24-12A-1

I, _____, being 18 years of age or older, direct that my body be cremated at my death.

[OPTIONAL] I further direct that my cremated remains be disposed of as follows:

_____

_____

_____

_____ _____

(signature of declarant) (date)

_____ _____

(signature of witness 1) (date)

_____ _____

(signature of witness 2) (date)

OR, IF NO WITNESSES:

_____ _____

(signature and seal of notary public) (date)

** If you wish to appoint a personal representative to carry out specific funeral instructions beyond just cremation, New Mexico law requires you to do so **in a will** (statute number 45-3-701 B). If you appoint such a person in your will, you may direct him or her to carry out specific instructions, or you may indicate that your representative has authority to make those decisions on your behalf. The personal representative named will have the sole legal right to carry out your funeral wishes. **Be sure to give a copy of your will to your personal representative. Do NOT put the only copy in a locked safe deposit box, as it may not be able to be retrieved in time for your funeral, thus thwarting your plans.***

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Part III: Your State's Estate Planning Forms

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524