Orthopedic Surgery & Sports Medicine
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Podiatric Surgery, Podiatry & Advanced Wound Care
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NEW MEXICO BONE & JOINT INSTITUTE
ALAMOGORDO · RUIDOSO · LAS CRUCES

Foot, Ankle & Lower Leg Reconstructive Surgery
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ADVANCED DIRECTIVES

Policy for Providing Patients with Advanced Directives

Purpose: The purpose of this policy is to ensure that patients at New Mexico Bone & Joint Institute (NMBJI) are informed about and have access to advanced directives in accordance with state laws and ethical standards.

Scope: This policy applies to all healthcare providers and administrative staff responsible for patient care and documentation at our practice.

Policy Statement:

1. **Distribution of Advanced Directives:**
   - Upon admission as a new patient, or during the first visit if the patient does not already have an advanced directive on file, the attending healthcare provider or designated staff member will provide the patient with a copy of the advanced directive form.
2. **Explanation and Discussion:**
   - The copy of the advanced directive form will have a complete description and explanation of what advanced directives are. If there are any additional questions by the patient, the patient can inform NMBJI.
3. **Documentation:**
   - A designated staff member will record in the patient's electronic health record (EHR) that the advanced directive has been offered and provided to the patient.
   - The patient will be asked to sign an acknowledgment form indicating that they have received a copy of the advanced directive document.
4. **Availability and Accessibility:**
   - Advanced directive forms will be readily available both in physical and electronic formats at the practice.
   - Patients who request a copy of their advanced directive at any time will be promptly provided with one.
5. **Review and Updates:**
   - During annual wellness visits or as medically appropriate, NMBJI will offer to update the advance directives with the directions of the patient.
6. **Compliance and Training:**
   - All staff members involved in patient care will receive training on this policy and the proper procedures for handling advanced directives.
   - Compliance with this policy will be periodically audited to ensure adherence.

NMBJI has provided: _____ _____

Patient Name DOB

_____ _____

Signature of patient Date

Introduction to Advance Directives

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What are Advance Directives?

Advance Directives are legal documents that allow you to plan and communicate your health care preferences in advance, in case you become unable to make decisions for yourself in the future. These documents ensure your wishes are known and respected by family members, caregivers, and health care professionals.

Why are Advance Directives important?

Advance Directives give you control over your medical treatment even when you cannot communicate your wishes. They provide guidance to your health care team and relieve your loved ones from making difficult decisions on your behalf without clear instructions.

What are the components of an Advance Directive?

1. Instructions for Health Care (Living Will): This part allows you to specify the type of medical care you want to receive if you are unable to communicate. It typically includes decisions about life-sustaining treatments, such as resuscitation, ventilation, and artificial nutrition.

2. Power of Attorney for Health Care: This part lets you appoint a trusted person (your agent) to make medical decisions on your behalf if you are unable to do so. Your agent should understand your values and preferences regarding medical care.

3. Advance Directive Form: This document combines your instructions for health care and power of attorney into a single legal form. It can be customized to reflect your specific wishes and preferences regarding medical treatment.

Instructions for Health Care (Living Will)

A Living Will is a part of the Advance Directive that allows you to outline your preferences for end-of-life medical care. It includes decisions about:

- Whether you want life-prolonging treatments if you have a terminal condition.

- Specific medical interventions you do or do not want, such as CPR, mechanical ventilation, or feeding tubes.

- Instructions regarding pain management and comfort care.

The Living Will helps guide your health care providers and loved ones in making decisions that align with your values and beliefs about medical care.

Power of Attorney for Health Care

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The Power of Attorney for Health Care (PAHC) allows you to appoint a person (your agent) to make health care decisions for you when you are unable to do so. Your agent should be someone who knows your values and preferences well, and whom you trust to act in your best interests. This person will advocate for your medical wishes and ensure they are followed by health care providers.

Advanced Directive for Mental Health

An Advance Directive for Mental Health is a specific type of Advance Directive that addresses your preferences for mental health treatment and care. It allows you to outline:

- Your preferences for psychiatric medications.

- Types of therapies or treatments you prefer or wish to avoid.

- Conditions under which you would or would not want to be hospitalized.

- Instructions for how you would like decisions about your mental health care to be made if you are unable to make them yourself due to a mental health crisis.

This document helps ensure that your mental health treatment aligns with your wishes, even if you are unable to communicate them at the time.

Conclusion

Advance Directives are powerful tools for asserting your autonomy and ensuring your medical wishes are respected during times of incapacity. They provide clarity and peace of mind for you, your loved ones, and your health care providers, making difficult decisions easier and more aligned with your personal values and beliefs. It's important to discuss your Advance Directive with your family, health care providers, and legal counsel to ensure everyone understands and respects your wishes.

ADVANCE DIRECTIVE FOR HEALTHCARE
NEW MEXICO

EXPLANATION

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make healthcare 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 have already signed a valid durable power of attorney for healthcare and/or right to die statement (living will), these statements are still valid. If you use this form, be sure to sign it and date it.

YOU DO NOT HAVE TO SIGN ANY FORM. If you do not sign a form or tell your doctor whom you want to make your healthcare decisions (or if someone you identify is not reasonably available), New Mexico law allows a family member who is reasonably available, to make your healthcare decisions. Family members are selected in the following order: 1) spouse, 2) significant other, 3) adult child, 4) parent, 5) adult brother or sister, 6) grandparent. If no family member is available, a close friend may act as a surrogate.

PART 1: POWER OF ATTORNEY FOR HEALTHCARE

Part 1 *of this form is a* ***power of attorney for healthcare****. It lets you name another individual as agent to make healthcare 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 alternate agents 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 healthcare institution at which you are receiving care.*

This form has a place for you to limit the authority of your agent. If you do not limit your agent's authority, your agent may make <u>all</u> healthcare decisions for you.

DESIGNATION OF AGENT: I appoint the following person as my agent to make healthcare decisions for me:

_____

(name of agent)

_____

(street address) *(city)* *(state)* *(zip code)*

_____

(home phone) *(work phone)*

If I revoke my agent's authority, or if my agent cannot or will not make a healthcare decision for me, then I appoint these persons as my alternative agents, to serve as follows:

(name of first alternative agent)	*(name of second alternative agent)*
(street address)	*(street address)*
(city, state, zip)	*(city, state, zip)*
(phone numbers: home / work)	*(phone numbers: home / work)*

AGENT'S AUTHORITY: *If you do not limit your agent's authority, your agent will have the right to:*

(1) consent or refuse consent to any medical care, treatment, service or procedure, such as:

- *diagnostic tests*
- *surgery*
- *medication*
- *hospitalization*
- *nursing care*
- *home healthcare*
- *orders not to resuscitate*
- *life saving and life prolonging medical treatment*
- *the provision, withholding or withdrawal of artificial nutrition and hydration*
- *all other forms of healthcare to keep me alive;* ***and***

(2) select or change healthcare providers and institutions.

My agent may make all healthcare decisions for me, including obtaining and reviewing medical records, reports and information about me, except to the extent I limit my agent's authority as follows:

(Add additional pages if needed)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified healthcare professional determine that I am unable to make my own healthcare decisions.

[ ] If I initial this box, my agent's authority to make healthcare decisions for me takes effect immediately.

AGENT'S OBLIGATION: My agent shall make healthcare decisions for me based on this **power of attorney for healthcare**, any healthcare 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 healthcare 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.

NOMINATION OF A 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 HEALTHCARE

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 fill out this part of the form, you may strike any wording you do not want.

END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my healthcare, 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 healthcare providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choices 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 healthcare standards.

[ ] I CHOOSE To Let My Agent Decide. My agent under my power of attorney for healthcare may make life sustaining treatment decisions for me.

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 (food) OR

[ ] I DO want artificial nutrition (food).

[ ] I DO NOT want artificial hydration (water) unless required for my comfort OR

[ ] I DO want artificial hydration (water).

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 be provided to keep me clean, comfortable and free of pain or discomfort at all times so that my dignity is maintained, even if this care hastens my death.

(Add additional pages if needed)

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 anatomical gift of any of my organs or tissue.

[ ] I CHOOSE to let my agent decide.

OTHER WISHES: *If you wish to write your own instructions, or you wish to add to the instructions you have given above, you may do so here.*

I direct that:

(Add additional pages if needed)

PART 3: DESIGNATION OF PRIMARY PHYSICIAN(S)

I designate the following physician as my primary physician. If the first physician I designate below is not willing, able or reasonably available to act as my primary physician, I designate the following alternate physician as my primary physician:

(name of physician)	*(name of alternate physician)*
(street address)	*(street address)*
(city, state, zip)	*(city, state, zip)*
(phone number)	*(phone number)*

OTHER PROVISIONS: I revoke any prior Advance Healthcare Directive.

This Advance Healthcare Directive shall become effective upon my disability or incapacity, unless I have initialed the appropriate box in *Part 1*, in which case, my agent's authority becomes effective immediately.

EFFECT OF COPY: A copy of this form has the same effect as the original.

REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTHCARE DIRECTIVE at any time~~.~~ , and that if I revoke it, I should promptly notify my supervising healthcare provider and any healthcare 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 healthcare provider.

SIGNATURE OF PRINCIPAL (Sign and date the form here)

(your signature)	*(date)*
(print your name)	*(your social security number - optional - verifies identity)*
(street address)	*(city)* *(state)* *(zip code)*

SIGNATURE OF WITNESSES

It is recommended, but not required, that you have two other individuals sign as witnesses

(signature of first witness) *(date)*	*(signature of second witness)* *(date)*
(print name of first witness)	*(print name of second witness)*
(address)	*(address)*
(city, state, zip)	*(city, state, zip)*