South Central
COLFAX
COUNTY
Special Hospital District

Admission Packet – Side 2

I have been informed, reviewed, signed (when appropriate), and understand the following documents:

- Admission Agreement
- Consent for Treatment
- Authorization to Announce
- Receipt of Resident Rights
- Resident Care Monitoring Act Authorization / Rejection
- Release of General Health Records
- Permission to Transport / Liability
- Resident Personal Funds
- Resident Personal Services Request
- Bed-Hold / Readmission Agreement
- Photo and Media Release
- Fall Risk
- Vaccine Authorization
- Resident Receipt of Required Documents
- Medication / Oxygen Arrangements
- Treatment Preference Sheet
- EMS / DNR
- Five Wishes (Advanced Directives)
- Valuable List

The information is correct and will remain in effect beginning the day of admission on _____/_____/_____.

_____ _____
Resident and / or Date:

_____ _____
Responsible Party: Date:

_____ _____
Witness: Date:

South Central COLFAX COUNTY
Special Hospital District

ADMISSIONS AGREEMENT

This agreement is made and entered into this _____day of _____ by and between the following parties:

Facility: Colfax General Long-Term Care

Resident: _____

Address: _____

_____

Responsible Person: _____

Relationship: _____

Address: _____

_____

and related to the provisions by Facility of the payment by or on behalf of Resident for long term nursing care services in accordance with the direction of Resident's physician.

I. Facility's Responsibilities.
In connection to the provision to Resident of the long term care services specified above, Facility does hereby agree as follows:

1. To furnish nursing, personal care, room and board to Resident in a manner and setting which complies with applicable local, state, and federal laws.

2. To oversee the medical care directed by Resident's physician.

3. To the extent required by applicable law, to provide or to contract for the provision of such specialized rehabilitation services as may be needed to improve or maintain Resident's level of care. If any specialized services that are needed are not available by Facility provisions or contract, assistance with finding a suitable facility will be provided.

4. To provide appropriate methods and procedures for the dispensing and administering of drugs prescribed by Resident's physician.

5. To provide or to contract for the provision of laboratory, x-ray, and other necessary diagnostic services.

6. To assist in arranging for the provision of routine and emergency dental care.

7. To identify the social and emotional needs of Resident, and to provide needed social services.

8. To provide an activities program appropriate to the needs and interests of Resident.

9. To maintain accurate medical records.

10. To have in place an agreement with an acute care facility for the transfer of Resident should such care be ordered by Resident's physician.

11. To provide a physical environment that is designed to maintain the health and safety of Resident, Facility personnel, and the public.

12. To provide such housekeeping and maintenance services as are necessary to maintain a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infections.

13. To provide such dietary services as are needed to meet Resident's daily nutritional needs.

14. To admit and treat Resident to the extent Facility is licensed or qualified to do so but without regard for race, creed, color, religion, national origin, or handicaps.

15. To provide all of the services provided for herein in a manner which complies with the applicable provision of the federal and/or state Resident's Bill of Rights and Responsibilities Responding to your needs and concerns the receipt of which Resident acknowledges by executing this agreement.

16. To transfer Resident from or within the Facility only for (a) his/her own welfare, (b) the welfare of other residents of the Facility, (c) nonpayment of stay, (d) improvement in Resident's health, or (e) Facility ceases to operate.

17. To reserve a bed per the bed hold policy distributed and reviewed with Resident and/or Responsible Person at the time of admission.

18. Colfax General will only disclose Resident's medical and/or financial records in accordance with this Notice of Privacy. Resident has been provided with the Notice of Privacy and Colfax General will comply with all terms specified.

II. Resident's/Responsible Person's Responsibilities.
In connection with the provision to Resident of the long-term services specified above, Resident does hereby agree as follows:

1. To pay the daily rate and any other applicable fees. Resident acknowledges that said additional fees shall include, but shall not be limited to, any co-payment required by the Medicaid Programs or by any other third party payer and/or payment for items or services not covered by said Programs or payers.

2. To cooperate with Facility in its efforts to ensure that Resident receives said nursing and/or medical care as may be directed by Resident's physician, and/or may be needed to protect the health and welfare of Resident, other Facility residents, Facility personnel, and the public.

3. In the case of Medicaid beneficiary, to timely file all such materials as may be necessary to obtain and/or maintain said coverage and to cooperate with Facility in its efforts to obtain payment for the services provided from said third party payers.

4. To comply with applicable Facility rules and regulations.

5. To cooperate in any transfers of Resident from or within the Facility where said transfers are in accordance with the terms of this agreement.

6. In the event Resident is transported in Facility van, to waive all claims against and release Colfax General Long Term Care and its managers, employees and volunteers, the driver or helper from any liability which might arise out of a trip away from the nursing home. This waiver shall be binding upon Resident's heirs, executors, and administrators.

7. To permit Facility to take such photographs of his/her person or portions thereof as may be necessary for identification, publicity, and/or medical purposes. Resident acknowledges that this consent is based on a full understanding of his/her right to privacy and right not to consent to such photography and thus that is given willingly and voluntarily.

8. In connection with the medical services provided to Resident. (a) to notify Facility of the identity of his/her attending physician; (b) to hold Facility harmless from any injury which Resident may incur as a result of the acts or omissions of Resident's physician unless Facility is proven to have been negligent in connection therewith; (c) to submit to any examination, treatment, procedure, or services ordered by his/her

physician and provided by Facility or such other health care facility or specialist as may be designated by Resident's physician. Resident or guardian may refuse examination and physician's orders either verbally or in writing, in which case the facility will be held harmless from any illness, injury, or death; and (d) to timely pay Facility for the provider, as appropriate, for all such services

9. To release Facility from any liability for damages or other loss which Resident might incur as a result of the disclosure by Facility of Resident's records in accordance with the provisions of Section I (18), above.

10. To the extent permitted by law, (a) to bring any claim against the Facility within one (1) year of the date on which said cause of action, be it contract, tort, or otherwise, accrues; (b) to release Facility from liabilities with respect to any losses incurred by Resident which are covered by insurance carried by or on behalf of Resident.

11. To leave the Facility only with the consent of his/her attending physicians and with notice to the Facility and to release the Facility from liability for any damages Resident may incur should he/she breach this agreement.

12. To cooperate with Facility in its efforts to ensure a safe and sanitary environment by cooperating with routine and as needed inspections and housecleaning of Resident's personal belongings.

III. Miscellaneous.

1. This agreement shall be governed by and construed in accordance with the laws of New Mexico.

2. This agreement represents the entirety of the agreement between the parties with respect to the subject matter hereof and supersedes all prior discussions, negotiations, and writings between them and cannot be modified or amended except by written instrument signed by the parties hereto.

3. This agreement shall be binding upon and shall insure to the benefit of successors and assigned of the parties hereto.

4. In the event of Resident's death, Facility shall release his/her body to the following Mortuary:

_____

_____

5. Should any provisions of this agreement be deemed to be invalid or unenforceable, said determination shall not affect the validity of the remainder of the agreement.

6. Nothing set forth herein shall impose upon Facility a duty to provide long tern care or other health related services on any basis other than that set forth herein.

7. No payment by Resident, Responsible Person, or any third party payer of less than full amount which is due and owing shall be treated otherwise than as a payment on account and the acceptance by Facility of a check for such lesser amount with an endorsement or statement thereon, or upon any letter accompanying such check, that it is deemed to be payment in full, shall be of no effect and thus may be accepted and cashed by Facility without prejudice to any of its rights and/or remedies.

8. This agreement may be terminated by Facility upon thirty (30) day written notice to Resident (or such longer period of time as may be specified by law) only for the reason set forth in section I (16), above.

9. By executing this agreement, Resident does not hereby delegate to Facility Responsibility for the management of his/her financial affairs. In consideration thereof Facility does hereby agree to provide Resident with a quarterly accounting of any and all transactions made on his/her behalf. (This provision may be deleted at Resident's option.)

Option I

I do hereby agree to be responsible for the satisfaction of any and all of my obligations, hereunder, including but not limited to, my obligation for services rendered hereunder.

_____ _____
Resident's Signature Date

_____ _____
Facility by Date:

Option II

Having legal access to _____ income, I acknowledge
(Resident's Name)
that I am responsible for providing payment to Colfax General LTC on a monthly basis from that said income. If I make payments from said income as stated I understand that this does not incur personal financial liability to me.

_____ _____
Name & Relationship Date

_____ _____
Facility by Date

Option III

Not having legal access to _____ income, who is
(Resident's Name)
legally incompetent. I'm merely agreeing that I have been made aware of the guidelines set forth in the Admission Agreement. I realize that I cannot be held responsible for costs incurred by said resident.

_____ _____
Name & Relationship Date

_____ _____
Facility by: Date

South Central COLFAX COUNTY
Special Hospital District

PATIENT AUTHORIZATION FORM
(PATIENT CARE MONITORING ACT)

I, _____ (resident/resident representative), hereby authorize and consent to the installation and use of the following type of monitoring device in my room:

_____ audio recorder
_____ video camera (must have date- and time- stamping capability)
_____ web camera (must have at least 128-bit encryption and enable a secure socket layer (SSL)
_____ other (specify) _____

Please provide the Make and Model Number and the date usage will began, if known: _____
_____

Please describe and conditions or limits you wish to place on the installation or use of the monitoring device. For example, in order to protect your privacy, you may limit the times of day that the device will operate, or you may limit the direction it will face, or its focus or volume. (If you do not wish to place any limits on the installation or use of the device, please state "NO LIMITS".):

_____
_____
_____
_____

I understand that, if I choose to install and use a monitoring device in my room or if I authorize my roommate to install and use one, I am waiving my right to privacy in conjunction with the use of the device, and I am releasing the facility from liability for a violation of my right to privacy insofar as the use of the device is concerned.

PLEASE CHOOSE ONE OF THE THREE OPTIONS LISTED BELOW:
(I understand that I may reverse or amend this decision at any time by simply completing a new form and delivering it to the facility.)

1. **MONITORING DEVICE AUTHORIZED:** I hereby authorize and consent to the installation and use of a monitoring device in my room on the terms described above. I understand that, if I have a roommate and my roommate does not consent, I may not install and operate a device until such time as consent is given. I understand that, if my roommate conditions or limits his or her consent, I must abide by the conditions or limits. If my roommate also wishes to install and use a device, I hereby consent to my roommate's installation and use of a device on terms that are no more restrictive than any that have been placed on my installation and use of a device.

   Signed:_____ Date:_____

2. **MONITORING DEVICE REJECTED BUT CONSENT GRANTED FOR ROOMMATE TO INSTALL AND USE ONE:** I do not want to install and use a monitoring device in my room, but if my roommate wants to install and use one, I hereby authorize and consent to the installation and use of a device on the terms described above.

   Signed:_____ Date:_____

3. **MONITORING DEVICE REJECTED:** I do not want a monitoring device in my room.

   Signed:_____ Date:_____

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RESIDENT RECEIPT OF REQUIRED DOCUMENTS

I, _____, on my own behalf or representing

_____ acknowledge receipt of the docu-
(Resident's Name)
ments listed below. Each document was reviewed with me and my questions concerning them have been answered to my satisfaction.

1. General Information about Colfax General long Term Care
2. Non-Discrimination Policy
3. Resident Rights and Responsibilities and Responding to Your Needs and Concerns
4. Abuse and Neglect
5. Restraint Use

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

South Central
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COUNTY
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CONSENT FOR TREATMENT

Consent is given to Colfax General Long Term Care and its employees to provide regular and customary services of the facility, and to administer the physician's orders for the treatment of my medical conditions. I have been informed by my physician of my medical condition(s).

I understand that I will be awarded the opportunity to participate in planning the treatment of my medical conditions. I will be duly informed of any changes in my medical condition.

_____ _____

Resident or Responsible Person Date

_____ _____

Witness Date

South Central
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COUNTY
Special Hospital District

AUTHORIZATION TO ANNOUNCE

I (or my appointed representative) _____
(Resident's Name)
_____ will be my spokesperson on my
Designee's Name)
behalf. I authorize this designated spokesperson to be my go between to other family members and loved ones. I authorize protected health information to be released as indicated on this form.

- **GENRAL INFORMATION:** Indicates a summary of overall statues, i.e. "They are in good shape." "They have taken a turn for the worse."
- **NO RELEASE OF INFORMATION:** Leads our staff to answer inquiries about your condition, "I'm not at liberty to answer any questions about that individual."
- **RELEASE OF MORE DETAILED INFORMATION:** Allows our staff to answer more specific questions about your condition. "Her blood pressure is elevated." "He was not able to eat much at breakfast."
- **RELEASE OF INFORMATION ON A NEED TO KNOW BASIS:** Authorizes staff members or Colfax General LTC to make a determination whether the one inquiring should know the information being asked or to what extent it should be released.

PLEASE MARK ALL THAT APPLY

_____ I authorize release of general information about my condition over the telephone or in person to my designated spokesperson.
_____ I authorize release of general information about my condition only in person to my designated spokesperson.
_____ I authorize release of general information to anyone inquiring.
_____ I authorize release of more detailed information to the following individuals or the following group (you may name names or specify *("family, friends, clergy, etc.")* and then indicate in person only or over the telephone.

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

South Central COLFAX COUNTY
Special Hospital District

AUTHORIZATION TO ANNOUNCE

_____I authorize release of the following specific information *(please mark as indicated)* to others who inquire as to my presence in the facility *(such a media, unlisted acquaintances, anyone who may inquire though not previously addressed.)*

_____ My name
_____ My religion preference _____ to clergy only
_____ My location
_____ My general condition

_____ I authorize the release of protected health information on a need to know basis to others that may be involved in my treatment *(consulted physicians or their staff, for example)* using the following means:

_____ Telephone
_____ Facsimile *(fax)*
_____ Other electronic means *(e-mail, for example)*
_____ US mail or other carrier

_____ I authorize the release of protected health information on a need to know basis to third party payers *(Medicare, Medicaid, and other Insurance)* for the sake of receiving payment for services using the following means:

_____ Telephone
_____ Facsimile *(fax)*
_____ Other electronic means *(e-mail, for example)*
_____ US mail or other carrier

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

South Central COLFAX COUNTY
Special Hospital District

RESIDENT RIGHTS
RESPONDING TO RESIDENT NEEDS

I, _____ and / or _____,
Resident Resident's Representative (DMPOA)

have received the Resident Rights information, the Resident Responsibilities document, and the Grievance policy. I have also been informed how to file a grievance, complaint, concern, or compliment Colfax General Long-Term regarding any aspect of Resident Rights.

_____ _____
Resident Date

_____ _____
Resident's Representative Date

_____ _____
Witness Date

COLFAX GENERAL LONG TERM CARE
AUTHORIZATION FOR RELEASE OF INFORMATION

DATE: _____

1. I Hereby authorize _____ to release the following
   Name of institution
   information from the health record (s) of:

   _____
   Patient Name

   _____
   Address

   Covering the period (s) of visits from:

   Date of Admission: _____
   Date of Discharge: _____
   Medical Record #: _____

2. Information to be released:
   ____ Copy of (complete) health record (s)
   ____ History & Physical
   ____ Consultation Reports
   ____ Discharge Summary
   ____ Operative Report
   ____ Emergency Reports
   ____ Drug & Alcohol Reports
   ____ X-ray Reports
   ____ Lab Reports
   ____ Physical Therapy Reports
   ____ Psychiatric Records
   ____ HIV Test Results
   ____ Other HIV related records

   Other: _____

3. Information to be released to: _____
   _____

4. Purpose of disclosure: _____
   _____

5. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this account. In any event this authorization expires with its execution.

6. This authorization may include disclosure of Alcohol and/ or drug use or abuse information which is protected by provisions in the Code of Federal Regulations (42-CFR, Part 2).

   This facility, its employees and officers are released from legal responsibility or liability for the release of the above information to the extent indicted and authorized herein.

Signed: _____

Patient or Representative: _____

Relationship: _____

Witness: _____ Date: _____

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PERMISSION TO TRANSPORT RESIDENT
GENERAL RELEASE OF LIABILITY

I, _____ am a resident of Colfax General
(Resident's Name)
Long-Term Care. I request that individuals assigned by Colfax General LTC transport me in a facility vehicle to medical appointments and errands as part of services rendered to me. I hereby release the individuals assigned and Colfax General LTC from any liabilities whatsoever, including but not limited to, any Injury, damage, or loss to me or my property caused, directly or indirectly, by transportation services provided to me.

I and my heirs, executors, administrators, heirs, successors, and assigns hereby fully release, acquit, and forever discharge Colfax General LTC and its directors, officers, agents, employees, servants, parent subsidiaries, successors, and liabilities of whatever nature, whether known or unknown, suspected or claimed, whatsoever, including without limitation any arising from common law or statute which I may agree to indemnify, defend and hold harmless Colfax General LTC and each of its representatives from any and all past, present, or future claims, demands, and/or cause of action brought in law or equity which might be claimed as a result of or in any way connected with the transportation services provided to me by Colfax General LTC.

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

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RESIDENTS PERSONAL FUNDS

The resident has the right to continue to manage his/her financial affairs residing in a nursing home. Upon written authorization from a resident, Colfax General Long Term Care (facility) will manage and account for any personal money left on deposit with the facility. This will allow the resident easy access to his/her money.

All money will be placed in an interest bearing account separate from any of the facility's operating accounts. Interest earned will be credited to the resident's personal account.

The facility will maintain a complete and separate accounting of all resident's personal money. A quarterly statement will be provided to the resident or responsible party showing all transactions for that quarter.

Upon resident's death, the facility will promptly refund the resident's funds to responsible party and final accounting of funds to the person administering the resident's estate.

Business office hours are from 8:00 a.m. to 4:30 p.m. Monday thru Friday.

_____I do hereby authorize Colfax General LTC to keep personal money in a trust account for safekeeping.

_____I do not wish to have Colfax General LTC handle my personal money while I am a resident in the facility.

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

Note:
Signature of responsible party may be accepted if the resident is medically incapable of understanding the authorization. If responsible party signs authorization the responsible party will be the one receiving the quarterly report.

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RESIDENTS PERSONAL FUNDS

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All money will be placed in an interest bearing account separate from any of the facility's operating accounts. Interest earned will be credited to the resident's personal account.

The facility will maintain a complete and separate accounting of all resident's personal money. A quarterly statement will be provided to the resident or responsible party showing all transactions for that quarter.

Upon resident's death, the facility will promptly refund the resident's funds to responsible party and final accounting of funds to the person administering the resident's estate.

Funds are provided by Business Office for resident use during office hours of 8am-4pm weekly and the total amount of $50.00 is provided during non-office hours/weekends by nursing staff.

_____I do hereby authorize Colfax General LTC to keep personal money in a trust account for safekeeping.

_____I do not wish to have Colfax General LTC handle my personal money while I am a resident in the facility.

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

Note:
Signature of responsible party may be accepted if the resident is medically incapable of understanding the authorization. If responsible party signs authorization the responsible party will be the one receiving the quarterly report.

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PERSONAL SERVICES REQUEST

LAUNDRY SERVICES

- This facility provides laundry services to the residents.
- All clothing items should by marked with an indelible maker.
- This facility will not be responsible for clothing that requires special laundry requirements.
- There is a $25.00 laundry service fee for private pay residents.
- Laundry to be done outside the facility will be kept in the resident's room in a covered plastic container *(provided by the facility)*.
- The soiled laundry should be picked up at least twice a week
- Failure to pick up soiled laundry will result in the facility doing the laundry.

_____ I do want Colfax General LTC to do my personal laundry.

_____ I do not want Colfax General LTC to do my personal laundry.

RESIDENTS MAIL

_____ Pass all mail to resident

_____ Hold all mail

_____ _____
Resident or Responsible Party Date

_____ _____
Witness Date

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BED HOLD & READMISSION AGREEMENT

- Private pay and veteran residents will be contacted by the business office each time they leave the facility overnight to determine whether they wish to pay to hold a bed during their absence. Regular daily payment rate will be required to hold the bed.

- Medicaid residents will have their bed held as long as they have leave days remaining. Each Medicaid resident receives six (6) leave days per year. The facility will attempt, but cannot guarantee, to hold the same bed.

- Each time a Medicaid resident leaves the facility, they and their sponsor will be notified again of the facility Bed Hold Agreement and the number of leave days available.

RE-ADMISSION

- All residents who leave the facility for hospitalization or therapeutic leave will be eligible for re-admission to the facility.

- Residents will be re-admitted to the facility to the first available bed as long as the resident still requires the services of the facility. Medicaid residents will be re-admitted as long as Medicaid covers the services they require.

_____ _____

Resident or Responsible Party Date

_____ _____

Witness Date

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PHOTO AND MEDIA RELEASE

I hereby authorize and consent to have my photograph taken.

A photograph will be placed by the door of my room and in the medication book as a means of identification.

My photograph and/or name may be released to the media during the coverage of a social or community function as a part of the Activities Program.

_____ _____

Resident or Responsible Party Date

_____ _____

Witness Date

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FALL RISK

The staff at Colfax General Long Term Care strives to keep our residents free from harm or injury. As our population ages, they become more fragile and the risk for falls increases.

Although we have a fall prevention program in place we do not guarantee that your loved one will not experience falls while under our care. This holds true especially in the case that your loved one has a history of falling at home.

Within 24 hours of admission, your loved one will be assessed for their level of fall risk and fall prevention interventions will immediately be put into place. Your loved one will be monitored by nursing staff at all times.
Every three months we hold an individual comprehensive care plan for each resident and a fall risk assessment is repeated and necessary changes will be added to their daily care.

_____ _____

Signature of Resident or Responsible Party Date

_____ _____

Witness Date

South Central COLFAX COUNTY
Special Hospital District

RESIDENT VACCINE AUTHORIZATION

Resident Name: _____ Medical Record #: _____

PCP: _____ Date: _____/_____/_____

The Resident may have an annual flu vaccine: Yes: _____ No: _____

Adverse reactions may include but are not limited to:

- Redness or pain at the injection site
- Fever
- Muscle Aches
- Nasal Congestion
- Irritability
- Tiredness

The Resident may have the pneumonia vaccine per CDC guidelines:
Yes: _____ No: _____

Adverse reactions may include but are not limited to:

- Redness or pain at the injection site
- Fever
- Muscle Aches
- Rarely, severe allergic reactions including hives, difficulty breathing and shock have occurred.

Date of last pneumonia vaccine?: _____/_____/_____

Is Resident allergic to eggs?: Yes: _____ No: _____

Has the Resident ever had an allergic reactions to the flu or pneumonia vaccine?:
Yes: _____ No: _____

_____ _____/_____/_____
Resident Signature Date

_____ _____/_____/_____
Responsible Party Signature Date

_____ _____/_____/_____
Witness Signature Date

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MEDICATION ARRANGMENTS

The resident or resident's responsible party needs to make arrangements with the pharmacy of their choice regarding the following:

- Payment for medications that Medicaid / private insurance does not cover.
- Inform the pharmacist and Colfax General LTC if the payment will be made by the responsible party or through the resident's trust fund.

OXYGEN ARRANGMENTS

If resident is on Medicare or will be private pay for their long-term stay, and is on oxygen, unless he /she is covered by a secondary insurance such as Blue Cross, Blue Shield, the resident (or responsible party) will be responsible for an oxygen concentrator fee of $176.60 per month or $6.00 per day. You may contact Allcare, Inc., 328 North Bonaventure Avenue, Trinidad, CO 81082 or by telephone @:

719-845-1986.

_____ _____

Signature of Resident or Responsible Party Date

_____ _____

Witness Date

South Central COLFAX COUNTY
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TREATMENT PREFERENCE SHEET

Resident Name:_____ Med. Rec. #_____

- I have been informed of my right to prepare Advanced Directives for my healthcare decisions.
- I have already prepared Advanced Directives._____(obtain a copy for resident's chart)
- I have appointed a Guardian _____, and / or Durable Power of Attorney for healthcare decisions. _____(obtain a copy for resident's chart).
- I do_____ I do not_____ wish to prepare Advanced Directives at this time.

In the absence of any directive, I understand that life-sustaining measures will be used:

_____ I DO want Cardiopulmonary resuscitation.	_____ I DO NOT want Cardiopulmonary resuscitation.
_____I DO want to receive artificial means of hydration.	_____ I DO NOT want to receive artificial means of hydration.
_____I DO want to receive artificial means of nutrition.	_____I DO NOT want to receive artificial means of nutrition.
_____I DO want to receive oxygen.	_____I DO NOT want to receive oxygen.
_____I DO want to be transferred to an acute care facility (hospital) if the physician determines it is necessary.	_____I DO NOT want to be transferred to an acute care facility (hospital) if the physician determines it is necessary.

This document will be reviewed with each admission. I understand that I have the right to revoke or change any part of this document.

_____ _____
Resident or Responsible Person Signature Date

_____ _____
Witness Signature Date

NEW MEXICO DEPARTMENT OF HEALTH

NEW MEXICO DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES (EMS) DO NOT RESUSCITATE (DNR) FORM

AN ADVANCE DIRECTIVE TO LIMIT THE SCOPE OF EMS CARE

NOTE: THIS ORDER TAKES PRECEDENCE OVER A DURABLE HEALTH CARE POWER OF ATTORNEY FOR EMS TREATMENT ONLY

I, _____, request limited EMS care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart functioning will be instituted, by any health care provider, including but not limited to EMS personnel.

I understand that this decision will not prevent me from receiving other EMS care, such as oxygen and other comfort care measures.

I understand that I may revoke this Order at any time.

I give permission for this information to be given to EMS personnel, doctors, nurses and other health care professionals. I hereby agree to this DNR Order.

_____ OR _____

Signature

Signature/Authorized
Health Care Decision Maker

_____

Relationship

I affirm that this patient/authorized health care decision maker is making an informed decision and that this is the expressed directive of the patient. I hereby certify that I or my designee have explained to the patient the full meaning of the Order, available alternatives, and how the Order may be revoked. I or my designee have provided an opportunity for the patient/authorized health care decision maker to ask and have answered any questions regarding the execution of this form. A copy of this Order has been placed in the medical record. In the event of cardiopulmonary arrest, no chest compressions, artificial ventilations, intubation, defibrillation, or cardiac medications are to be initiated.

_____ _____

Physician's Signature / Date

Physician's Name - PRINT

_____

Physician's Address / Phone

White Copy: To be kept by patient in white envelope and immediately available to Emergency Responders
Yellow Copy: To be kept in patient's permanent medical record
Pink Copy: If DNR Bracelet/Medallion is desired send to MedicAlert with enrollment form.

2/95

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.

South Central COLFAX COUNTY
Special Hospital District

VALUABLE'S LIST

Resident Name:	Medical Record #:
Room #:	Physician:

JEWELRY:

Item	Item Description
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

PHOTOGRAPHS / ALBUMS:

Item	Item Description
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

CLOTHES / BLANKETS / OTHER:

Item	Item Description
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

ADAPTIVE EQUIPMENT / PROSTHETICS:

Item	Item Description
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Family/ Resident Signature Staff Signature Date