

## HEALTH CARE POWER OF ATTORNEY QUESTIONNAIRE

Please complete this form with as much information as you can and return it to Wendell L. Hawkins, PA via fax (864) 243-8137 or email [greenville@wlhawkinslawfirm.com](mailto:greenville@wlhawkinslawfirm.com)

A. YOUR AGENT OR ALTERNATES MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

B. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

### 1. DESIGNATION OF HEALTH CARE AGENT

I, \_\_\_\_\_, (Your name), hereby appoint:

(Agent's Name) \_\_\_\_\_

(Agent's Address) \_\_\_\_\_

Telephone: home: \_\_\_\_\_ work: \_\_\_\_\_ mobile: \_\_\_\_\_  
\_\_\_\_\_ as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

**a. First Alternate Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: home: \_\_\_\_\_ work: \_\_\_\_\_ mobile: \_\_\_\_\_  
\_\_\_\_\_

**b. Second Alternate Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: home: \_\_\_\_\_ work: \_\_\_\_\_  
mobile: \_\_\_\_\_

THE FOLLOWING IS AN EXCERPT FROM THE HEALTH CARE POWER OF ATTORNEY AND YOU WILL HAVE TO CHOOSE AT SIGNING ONE OF THE VARIOUS CHOICES. THIS IS PROVIDED SO THAT YOU WILL BE BETTER PREPARED TO MAKE THOSE CHOICES AT SIGNING.

#### 4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation.

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death.

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service.

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

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#### 5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may \_\_\_\_; may not \_\_\_\_ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

## 6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

## 7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

(1) \_\_\_ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) \_\_\_ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) \_\_\_ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

## 8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Item 7,  
(INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS):

(a) \_\_\_ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

(b) \_\_\_ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(c) \_\_\_ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.