ELDER JUSTICE CENTER
779 Route 4, Suite E
Sinajana, Guam 96910
Tel. No. 671-300-7809
support@guamejc.org

POWER OF ATTORNEY FOR HEALTHCARE QUESTIONNAIRE

Client Full Name: ______________________ Date of Birth: ____________
Address: ______________________ Telephone: ____________ Email: ____________

Person whom you will grant power to:

Full Name: ______________________ Date of Birth: ____________
Address: ______________________ Telephone: ____________ Email: ____________

Alternate person whom you will grant power to:

Full Name: ______________________ Date of Birth: ____________
Address: ______________________ Telephone: ____________ Email: ____________

What are the powers that you want them to have:	
☐	To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medications. **This includes decisions about using mechanical or other procedures that affect any bodily function, such as artificial respiration, cardiopulmonary resuscitation, or other forms of medical support, even if deciding to stop or withhold treatment could or would result in my death.**
☐	To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.
☐	To have access to medical records and information to the same extent that I am entitled to, including the right to disclose health information to others.
☐	To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted-living or similar facility or service.
☐	To contract for any health care-related service or facility for me, or apply for public or private health care benefits, with the understanding that my agent is not personally financially responsible for those contracts.
☐	To hire and fire medical, social service, and other support personnel who are responsible for my care.
☐	To authorize my participation in medical research related to my medical condition.
☐	To decide about organ and tissue donations, autopsy, and the disposition of my remains as the law permits.
☐	To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.
DO YOU HAVE AN ADVANCE DIRECTIVE? (<u>Choose one only</u>)	
☐	I previously executed a Living Will or other Advance Directive for medical care. (THIS DOES NOT TAKE THE PLACE OF MY LIVING WILL. Should there be a conflict between this Directive and my Living Will, my Living Will controls.)
☐	I do not have any previous advance directives. (This will be the first advance health directive I make. I do not have a Living Will. My Health Care Agent will make all decisions.)