

# LASTING POWER OF ATTORNEY QUESTIONNAIRE

## HEALTH & WELFARE

**SABLE**  
a professional edge

### Personal details

Title	
Forename (s)	
Surname	
Address	
Date of Birth	
Nationality	
Occupation	
Earnings	
Home telephone	
Work telephone	
Mobile telephone	
e-mail	

Are you known by any other names in medical or welfare records?

Are happy for documentation to be sent via e-mail	YES	NO
Would you like to speak to a financial advisor	YES	NO

### Previous LPAs

Have you already signed a LPA?	YES	NO
If yes, please provide a copy.		

Please provide a brief reason for your request to have an LPA.

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### Information provided:

Do you give the information in this questionnaire freely and voluntarily?	YES	NO
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## Attorneys

Please provide the details of the individual you want to appoint as your attorney. You can choose more than one attorney; however, he/she must be over the age of 18 years and must not be bankrupt or insolvent.

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

## Replacement attorneys

Replacement attorneys will only act in the event that your attorney can no longer act for you.

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

How do you want your attorney to make decisions?

JOINTLY
JOINTLY & SEVERALLY
JOINTLY FOR SOME DECISIONS, AND JOINTLY AND SEVERALLY FOR OTHER DECISIONS

Please explain below which decisions are to be made jointly and which jointly and severally:

### Life sustaining treatment

**Do you want your attorney(s) to have the authority to give or refuse consent to life-sustaining treatment on your behalf?**

Life sustaining treatment can include:

- a serious operation, such as heart bypass surgery.
- chemotherapy, radiotherapy or another cancer treatment.
- an organ transplant.
- artificial nutrition or hydration (food or water given other than by mouth).

Option A	YES
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or

Option B	NO
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What restrictions and conditions do you want imposed concerning your health and welfare?

What guidance do you wish your attorney to have in mind when considering your health and welfare?

What agreement have you made with your attorney regarding costs for acting as your attorney?

**Who is to be notified when you apply to register the LPA?**

You can choose up to five people to be when your LPA is being registered. You are not obliged to choose anyone; however, if you do not choose anyone then you will need two certificate providers.

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Title	Full name	Date of birth
Telephone number		Email address
Address		
Relationship to you		

Please supply any further information below that may be relevant to your circumstances.

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Full Name(s)	
Signed	
Date	

If you have any questions, please contact Sable Wills on **+44 (0)20 7759 5531** or email **wills@sable-group.com**