UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

IN RE:	)	MDL Docket No. 1953
HEPARIN PRODUCTS LIABILITY LITIGATION	)	CHIEF JUDGE JAMES G. CARR CASE NO. 1:08-60000
	)	ALL CASES

SECOND AMENDED PRETRIAL ORDER NO. 10

PLAINTIFF FACT SHEETS

1. The three forms of Heparin Plaintiff Fact Sheet ("PFS") attached hereto as Exhibit 1 (kidney dialysis patients), Exhibit 2 (cardiac procedure patients) and Exhibit 3 (other procedure patients) have been agreed to by the parties and are approved for use in this litigation.

2. Each Plaintiff in an action currently pending before the Court in MDL 1953 shall complete and serve upon Defendants BHC, BII, SPL, and CZSPL's Lead Counsel (Leslie M. Smith, Kirkland & Ellis, LLP, 200 E. Randolph Drive, Chicago, IL 60601) a PFS in one of the three forms approved by the Court. If B. Braun Medical, Tyco Healthcare Group LP d/b/a Covidien, Medefil, Inc., or other Defendants are named, then a PFS shall be served on each defense attorney representing any and all such Non-Baxter/SPL Defendants.

3. Each Plaintiff in an action currently pending before the Court in MDL 1953 shall also complete and serve upon Receiving Defendant Counsels: 1) a completed List of Medical Providers and Other Sources of Information ("LMP") in the form attached as Exhibit A to the PFS, and 2) signed original medical release authorizations for each of the entities and individuals identified in the LMP in the form attached as Exhibit B to the PFS.

4. Simultaneous to service upon Receiving Defendant Counsels, each Plaintiff also shall serve a copy of the completed PFS, including Exhibit A (without medical records,

authorizations for medical records, or attachments)on Plaintiffs' Federal Court Liaison Counsel (David W. Zoll, Zoll, Kranz & Borgess, 6620 West Central Avenue, Toledo, Ohio 43617).

5. For all cases transferred to MDL 1953 after the date of the entry of this Order, the Plaintiff shall have 30 days from the date the case is assigned a case number in the MDL, to complete and serve the PFS, LMP and the signed original medical release authorizations as set forth above. Receiving Defendant Counsels will notify each new plaintiffs' counsel of his/her obligations under this paragraph.

6. All persons asserting claims for personal injuries allegedly caused by contaminated heparin must complete and timely serve a PFS, LMP and signed original medical release authorizations in accordance with this Order. Defendants reserve their rights to seek any and all available relief available under the applicable federal rules for the failure to timely complete such documents.

7. Nothing in the PFS and LMP shall be deemed to limit the scope of inquiry at depositions or admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Federal Rules of Civil Procedure. The admissibility of information in the PFS and LMP shall be governed by the Federal Rules of Evidence and no objections are waived by virtue of any fact sheet response.

8. All completed PFS and LMP forms are subject to the confidentiality provisions of Pretrial Order No. 7, as amended.

Accordingly, IT IS HEREBY ORDERED, ADJUDGED AND DECREED.

This 5 day of February, 2009

/s/ James G. Carr
JAMES G. CARR, United States District Judge

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO

IN RE:	)	MDL Docket No. 1953
HEPARIN PRODUCTS LIABILITY LITIGATION	)	CHIEF JUDGE JAMES G. CARR CASE NO. 1:08-60000
	)	ALL CASES

AMENDED PRETRIAL ORDER NO. 10

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1. The three forms of Heparin Plaintiff Fact Sheet ("PFS") attached hereto as Exhibit 1 (kidney dialysis patients), Exhibit 2 (cardiac procedure patients) and Exhibit 3 (other procedure patients) have been agreed to by the parties and are approved for use in this litigation.

2. Each Plaintiff in an action currently pending before the Court in MDL 1953 shall complete and serve upon Defendants' Lead Counsel (Leslie M. Smith, Kirkland & Ellis, LLP, 200 E. Randolph Drive, Chicago, IL 60601 and Adam Le Berthon, Arnold & Porter LLP, 777 S. Figueroa Street, Suite 4400, Los Angeles, CA 90017) a PFS in one of the three forms approved by the Court within 60 days of the date of the entry of this Order.

3. Each Plaintiff in an action currently pending before the Court in MDL 1953 shall also complete and serve upon Defendants' Lead Counsel, within 60 days of the date of the entry of this Order: 1) a completed List of Medical Providers and Other Sources of Information ("LMP") in the form attached as Exhibit A to the PFS, and 2) signed original medical release authorizations for each of the entities and individuals identified in the LMP in the form attached as Exhibit B to the PFS.

4. Simultaneous to service upon Defendants' Lead Counsel, each Plaintiff shall also serve a copy of the completed PFS, including Exhibit A (without medical records, authorizations

for medical records, or attachments) on Plaintiffs' Federal Court Liaison Counsel (David W. Zoll, Zoll, Kranz & Borgess, 6620 West Central Avenue, Suite 200, Toledo, Ohio 43617).

5. For all cases transferred to MDL 1953 after the date of the entry of this Order, the Plaintiff shall have 30 days from the date the case is assigned a case number in the MDL, or 60 days from the entry of this Order (whichever is longer), to complete and serve the PFS, LMP and the signed original medical release authorizations as set forth above. Defendants' Lead Counsel will notify each new plaintiffs' counsel of his/her obligations under this paragraph.

6. All persons asserting claims for personal injuries allegedly caused by contaminated heparin must complete and timely serve a PFS, LMP and signed original medical release authorizations in accordance with this Order. Defendants reserve their rights to seek any and all available relief available under the applicable federal rules for the failure to timely complete such documents.

7. Nothing in the PFS and LMP shall be deemed to limit the scope of inquiry at depositions or admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the Federal Rules of Civil Procedure. The admissibility of information in the PFS and LMP shall be governed by the Federal Rules of Evidence and no objections are waived by virtue of any fact sheet response.

8. All completed PFS and LMP forms are subject to the confidentiality provisions of Pretrial Order No. 7, as amended.

Accordingly, IT IS HEREBY ORDERED, ADJUDGED AND DECREED.

This 21 day of October 2008

s/James G. Carr

JAMES G. CARR, United States District Judge

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

IN RE: HEPARIN PRODUCTS LIABILITY LITIGATION	)	MDL Docket No. 1953
	)	Chief Judge James G. Carr
THIS DOCUMENT RELATES TO MDL DOCKET NO. 1953	)	
PLAINTIFF: _____	)	
NAME(S)	)	

HEPARIN PLAINTIFF FACT SHEET: KIDNEY DIALYSIS

If you believe you were administered contaminated Heparin during KIDNEY DIALYSIS, please COMPLETE THIS FACT SHEET.

In completing this Fact Sheet, you are under oath and must provide information that is true and accurate to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this Fact Sheet. If you are completing the Fact Sheet as the authorized legal representative on behalf of the person who received contaminated Heparin, please answer the questions as completely as you can for that person.

Please attach as many additional sheets of paper as necessary to fully complete each question on this Fact Sheet.

PART I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____
2. MDL Civil Action No.: _____

[Please Note: If you are completing this Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Heparin. Those questions using the term "You" refer to the person who used Heparin. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

B. Claim Information:

1. Name, address, telephone number, fax number and e-mail address of the principal attorney representing you in this lawsuit:

Name: _____

Firm: _____

Street Address: _____

City, State, and Zip Code: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

THE REST OF THIS FACT SHEET REQUIRES INFORMATION ABOUT THE PERSON WHO USED HEPARIN.

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PART II. PERSONAL INFORMATION

A. Identifying Information:

1. _____ _____ _____
   Last Name First Name Middle Name

2. Maiden or other names used or by which you have been known: _____

3. Current Address:

   Street Address: _____

   City, State, and Zip Code: _____

4. Current or Last Employer:

   Name: _____

   Street Address: _____

   City, State, and Zip Code: _____

   Dates of Employment: _____

   Occupation: _____

5. Social Security Number: _____

6. Date of Birth: Month: _____ Day: _____ Year: _____

7. Sex: Male: ☐ Female: ☐

B. Have you ever filed a worker's compensation claim; social security disability claim; or a lawsuit, other than the present suit, relating to any bodily injury? ..... Yes: ☐ No: ☐

If yes, for each such claim please state:

Type of claim filed (e.g., worker's compensation, social security, etc.): _____

Date claim was filed: _____

Where claim was filed (e.g., court, department, organization, etc.): _____

Claim/docket number, if applicable: _____

Nature of claim/disability: _____

Period of disability: _____

PART III. PLAINTIFF CURRENT MEDICAL CONDITION

A. Is plaintiff deceased? Yes: ☐ No: ☐ If yes, please proceed to Part IV. If no, please answer question III. B-C.

B. Height: _____ Current Weight: _____

C. Do you currently suffer from any of the following diseases or conditions?

1. Hypertension/high blood pressure ..... Yes: ☐ No: ☐
2. Diabetes or metabolic syndrome ..... Yes: ☐ No: ☐
3. Kidney disease or failure ..... Yes: ☐ No: ☐
4. Thyroid disorder ..... Yes: ☐ No: ☐
5. HIV or AIDS ..... Yes: ☐ No: ☐
6. Atherosclerosis ..... Yes: ☐ No: ☐
7. Asthma ..... Yes: ☐ No: ☐
8. Connective tissue or autoimmune disease (including lupus, rheumatoid arthritis, sarcoidosis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
9. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐

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11. Anemia ..... Yes: ☐ No: ☐
12. Arrhythmia ..... Yes: ☐ No: ☐
13. Bleeding or clotting disorders (including hemophilia or Heparin-induced thrombocytopenia (HIT)) ..... Yes: ☐ No: ☐
14. Cancer ..... Yes: ☐ No: ☐
15. Vasculitis ..... Yes: ☐ No: ☐
16. Lung disease (including but not limited to COPD and emphysema) ..... Yes: ☐ No: ☐
17. Other*_____ ..... Yes: ☐ No: ☐

    * Please identify any other disease(s) or medical condition(s) that require(s) in-patient or out-patient medical care and/or results in continuing or periodic episodes of incapacity.

For each disease or condition identified above, provide the following information:

Injury/Illness/Disability	Approximate Date of Onset	Approximate Date of Diagnosis	Name and Address of First Diagnosing Physician

PART IV. PLAINTIFF MEDICAL BACKGROUND

A. Smoking history: Never smoked cigarettes: ☐ Past smoker of cigarettes: ☐ Current smoker of cigarettes: ☐
If past or current smoker: _____ packs per day for _____ years.

B. Medications

1. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you were taking regularly or periodically WITHIN THE SIX MONTHS BEFORE the date(s) on which you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

2. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you took WITHIN 24 HOURS BEFORE or AFTER the time(s) that you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

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C. To the best of your knowledge, did you ever experience any of the following DURING THE FIVE YEARS BEFORE the injury that forms the basis of your claims in this lawsuit?

1. Shortness of breath not associated with vigorous exercise ..... Yes: ☐ No: ☐
2. Chest tightness ..... Yes: ☐ No: ☐
3. Persistent or recurrent pain in chest ..... Yes: ☐ No: ☐
4. Low blood pressure ..... Yes: ☐ No: ☐
5. Irregular heart beat, including heart palpitations, tachycardia and/or bradycardia ..... Yes: ☐ No: ☐
6. Audible wheezing ..... Yes: ☐ No: ☐
7. Swelling in the mouth or throat or difficulty swallowing ..... Yes: ☐ No: ☐
8. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
9. Swelling in the hands ..... Yes: ☐ No: ☐
10. Numbness or tingling ..... Yes: ☐ No: ☐
11. Generalized or localized sensations of burning or warmth ..... Yes: ☐ No: ☐
12. Dizziness or lightheadedness ..... Yes: ☐ No: ☐
13. Fainting ..... Yes: ☐ No: ☐
14. Chronic nausea, vomiting, or diarrhea ..... Yes: ☐ No: ☐
15. Chronic abdominal pain ..... Yes: ☐ No: ☐
16. Hives or urticaria ..... Yes: ☐ No: ☐
17. Seizures ..... Yes: ☐ No: ☐
18. Skin rashes ..... Yes: ☐ No: ☐
19. Flushing of face or other parts of the body ..... Yes: ☐ No: ☐
20. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐
21. Blurred vision ..... Yes: ☐ No: ☐

D. If you responded yes to any of the above, state the following:

Condition(s)	Approximate Date of Onset	Circumstances Under Which Condition(s) Occurred	Duration of Condition(s)	Name and Address of Physician (if any)

E. To the best of your knowledge, have you ever been told by a doctor or any other health care professional that you have, or may have, or had any of the following:

1. Hypotension or low blood pressure ..... Yes: ☐ No: ☐
2. Hypertension or high blood pressure ..... Yes: ☐ No: ☐
3. Fluctuating blood pressure ..... Yes: ☐ No: ☐
4. Thrombocytopenia or low blood platelet count .... Yes: ☐ No: ☐
5. Heart disease or heart failure ..... Yes: ☐ No: ☐
6. Heart arrhythmia ..... Yes: ☐ No: ☐
7. Atrial fibrillation ..... Yes: ☐ No: ☐
8. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐

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9. Myocardial infarction (heart attack) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐
11. Vascular artery disease ..... Yes: ☐ No: ☐
12. Valvular heart disease ..... Yes: ☐ No: ☐
13. Stroke or transient ischemic attack ..... Yes: ☐ No: ☐
14. Anemia, bleeding, or hemorrhagic disorder ..... Yes: ☐ No: ☐
15. Blood clotting disease or disorder ..... Yes: ☐ No: ☐
16. Seizures ..... Yes: ☐ No: ☐
17. Liver disease (including but not limited to hepatitis) ..... Yes: ☐ No: ☐
18. Diabetes ..... Yes: ☐ No: ☐
19. Adverse reaction to immunization ..... Yes: ☐ No: ☐
20. Hypersensitive or allergic reaction to any drug .... Yes: ☐ No: ☐
21. Hypersensitive or adverse reaction to Heparin ..... Yes: ☐ No: ☐
22. Eczema ..... Yes: ☐ No: ☐
23. Connective tissue or autoimmune disease (including but not limited to lupus, rheumatoid arthritis, sarcoidosis, vasculitis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
24. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
25. Asthma ..... Yes: ☐ No: ☐
26. Lung disease (including but not limited to COPD and emphysema)..... Yes: ☐ No: ☐
27. Pulmonary embolism..... Yes: ☐ No: ☐
28. Superficial or deep venous thrombosis ..... Yes: ☐ No: ☐
29. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐

F. If you responded yes to any of the above, please complete the following:

Condition(s)	Approximate Date of Onset	Name and Address of Physician

G. Have you ever been evaluated or treated by an allergist or immunologist? ..... Yes: ☐ No: ☐
If yes, please provide the following for each allergist or immunologist who has evaluated or treated you:

Name	Address	Approximate Date(s) of Evaluation/Treatment	Reason(s) for Evaluation/Treatment

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H. To the best of your knowledge, have you ever experienced an allergic reaction to any of the following:

1. Food..... Yes: ☐ No: ☐
2. Drugs or medications (including but not limited to antibiotics, anesthesia, and Heparin)..... Yes: ☐ No: ☐
3. Seasonal irritants (e.g., pollens, grass, trees, etc.). Yes: ☐ No: ☐
4. Insects..... Yes: ☐ No: ☐
5. Animals (including animal fur and dander)..... Yes: ☐ No: ☐
6. Mold..... Yes: ☐ No: ☐
7. Dyes..... Yes: ☐ No: ☐
8. Latex..... Yes: ☐ No: ☐
9. Other..... Yes: ☐ No: ☐

I. If you responded yes to any of the above, please complete the following:

Substance	Nature of the Reaction	Approximate Date(s)	Name and Address of Physician (if any)

J. To the best of your knowledge, did you ever receive Heparin prior to the date on which you claim you received contaminated Heparin? ..... Yes: ☐ No: ☐

K. Before your claimed exposure to contaminated Heparin, did you ever suffer an adverse reaction to the administration of Heparin? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

L. Before your claimed exposure to contaminated Heparin, did you ever experience an adverse reaction to a transfusion of blood or any blood product (e.g., plasma)? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

M. Please complete the following information for any surgery that you have had within the past 10 years and for any surgery involving the heart, chest, lungs, amputations, or organ transplants that you have had at ANY TIME.

Type of Surgery	Approximate Date of Surgery	Hospital or Other Surgical Facility	Name and Address of Surgeon

PROTECTED DOCUMENT SUBJECT TO PROTECTIVE ORDER

PART V. FAMILY MEDICAL BACKGROUND

A. Has any parent, sibling or offspring been diagnosed with, experienced or suffered from the following:

1. Adverse reactions to anesthesia ..... Yes: ☐ No: ☐ Don't know: ☐
2. Adverse reactions to immunization ..... Yes: ☐ No: ☐ Don't know: ☐
3. Hypersensitivity/adverse reaction to Heparin ..... Yes: ☐ No: ☐ Don't know: ☐
4. Adverse reactions to dialysis ..... Yes: ☐ No: ☐ Don't know: ☐

B. If you responded yes to any of the above, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Condition Listed Above

C. Has any parent, sibling or offspring had a history of severe allergic reactions requiring hospitalization or injection with epinephrine? ..... Yes: ☐ No: ☐ Don't know: ☐

If yes, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Reaction

PART VI. PRODUCT IDENTIFICATION

A. Do you contend that you have suffered an injury as a result of the administration of contaminated Heparin?..... Yes: ☐ No: ☐

If yes, please provide the following information (if known).

1. Manufacturer: _____
2. Distributor: _____
3. Lot Number: _____
4. Date administered: _____
5. Method of administration: _____
6. Amount administered: _____
7. Physician/clinic: _____

B. If you contend you received contaminated Heparin on more than one occasion, please attach additional sheets as necessary to provide the information for each such occasion.

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PART VII. KIDNEY DIALYSIS

A. Kidney Disease and Treatment:

1. Identify the medical condition that caused your kidney (renal) disease: _____

_____

2. Identify all types of treatment you have received for kidney disease (e.g., hemodialysis, peritoneal dialysis, kidney transplant, etc.) and the dates of each treatment.

Treatment(s)	Approximate Date(s) of Treatment	Treating Physician	Hospital or Clinic

3. If you have had a kidney transplant or are now or have ever been on a kidney transplant list, identify the hospital or medical facility where the transplant was or is to be performed.

_____

4. Kidney dialysis:

Dialysis Date(s)	Type of Dialysis (Hemodialysis or Peritoneal Dialysis)	Treating or Supervising Physician	Hospital or Clinic

5. How frequently were you having dialysis at the time you claim you received contaminated Heparin?

_____

6. How long were you at dialysis sessions at the time you claim you received contaminated Heparin?

_____

7. On average, how much weight were you gaining between dialysis sessions at the time you contend you received contaminated Heparin?

_____

8. During the five years BEFORE your claimed exposure to contaminated Heparin, did you experience any of the following adverse reactions DURING OR WITHIN 24 HOURS FOLLOWING dialysis:

1. Anaphylaxis reaction ..... Yes: ☐ No: ☐
2. Adverse reaction to dialyzer ..... Yes: ☐ No: ☐
3. Adverse reaction to dialysis membrane ..... Yes: ☐ No: ☐
4. Adverse reaction to medication (e.g., antibiotics) ..... Yes: ☐ No: ☐
5. Adverse reaction to reuse agent(s) ..... Yes: ☐ No: ☐
6. Adverse reaction to iron ..... Yes: ☐ No: ☐
7. Burning sensation at access site ..... Yes: ☐ No: ☐
8. Shortness of breath ..... Yes: ☐ No: ☐
9. Chest tightness ..... Yes: ☐ No: ☐
10. Persistent or recurrent pain in your chest ..... Yes: ☐ No: ☐
11. Low blood pressure ..... Yes: ☐ No: ☐
12. Irregular heart beat, including heart palpitations and/or tachycardia.... Yes: ☐ No: ☐
13. Bradycardia ..... Yes: ☐ No: ☐

PROTECTED DOCUMENT SUBJECT TO PROTECTIVE ORDER

14. Audible wheezing ..... Yes: ☐ No: ☐
15. Swelling in the mouth or throat or difficulty swallowing ..... Yes: ☐ No: ☐
16. Angioedema (swelling of the lips, tongue or eyelids) ..... Yes: ☐ No: ☐
17. Swelling in the hands ..... Yes: ☐ No: ☐
18. Numbness or tingling ..... Yes: ☐ No: ☐
19. Generalized or localized sensation of warmth ..... Yes: ☐ No: ☐
20. Dizziness or lightheadedness ..... Yes: ☐ No: ☐
21. Fainting ..... Yes: ☐ No: ☐
22. Nausea, vomiting, or diarrhea ..... Yes: ☐ No: ☐
23. Abdominal pain ..... Yes: ☐ No: ☐
24. Hives or urticaria ..... Yes: ☐ No: ☐
25. Seizures ..... Yes: ☐ No: ☐
26. Sudden episodes of itching ..... Yes: ☐ No: ☐
27. Skin rashes ..... Yes: ☐ No: ☐
28. Flushing of face or other part of body ..... Yes: ☐ No: ☐
29. Blurred vision ..... Yes: ☐ No: ☐
30. Muscle cramping ..... Yes: ☐ No: ☐
31. Headache ..... Yes: ☐ No: ☐
32. Back pain ..... Yes: ☐ No: ☐
33. Fever or chills ..... Yes: ☐ No: ☐
34. Excessive yawning ..... Yes: ☐ No: ☐
35. Sneezing ..... Yes: ☐ No: ☐
36. Dialysis disequilibrium syndrome ..... Yes: ☐ No: ☐
37. Dehydration ..... Yes: ☐ No: ☐

9. If you responded yes to any of the above, please complete the following:

Condition/ Reaction	First Date of Occurrence	Onset Time (e.g., 10 minutes after dialysis begins)	Duration	Frequency of Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)	Response (e.g., give saline, stop treatment, stop fluid removal)	Physician or Dialysis Administrator	Hospital or Clinic

10. In addition to the medications listed in Part IV above, have you ever received any of the following medications in connection with your dialysis treatment?

1. Antibiotics ..... Yes: ☐ No: ☐ Don't know: ☐
2. Midodrine (brand name ProAmatine) ..... Yes: ☐ No: ☐ Don't know: ☐
3. Steroids ..... Yes: ☐ No: ☐ Don't know: ☐
4. Iron ..... Yes: ☐ No: ☐ Don't know: ☐
5. Erythropoiesis Stimulating Agents (ESAs) (e.g., Epogen, Procrit) ..... Yes: ☐ No: ☐ Don't know: ☐

B. Claimed Exposure and Response to Contaminated Heparin.

1. Date and approximate time that your dialysis treatment began: _____

2. Date and time that you believe you experienced symptoms allegedly related to contaminated Heparin.

_____

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3. Describe in detail the injuries and symptoms you believe you suffered as a result of administration of contaminated Heparin:

_____

_____

_____

_____

a. How soon after administration of the Heparin did you suffer your claimed injuries and symptoms?

_____

b. How long did the injuries and symptoms last? _____

c. Was Heparin administration discontinued as a result of your reaction? _____

4. Identify the person(s) who administered and/or monitored the dialysis session during which you believe you received contaminated Heparin. _____

5. Facility where you believe you received contaminated Heparin. _____

6. Identify the type of kidney dialyzer and sterilization used. _____

7. Describe in detail any treatment you received for the injuries and symptoms described in response to Question B.3 above, if any, including any hospitalization.

_____

_____

_____

_____

8. Were you given any of the following medications to treat the injuries and symptoms experienced after your alleged receipt of contaminated Heparin?

a. protamine sulfate ..... Yes: ☐ No: ☐ Don't know: ☐
b. antihistamines ..... Yes: ☐ No: ☐ Don't know: ☐
c. corticosteroids ..... Yes: ☐ No: ☐ Don't know: ☐
d. epinephrine ..... Yes: ☐ No: ☐ Don't know: ☐

9. Did you experience any change in kidney function following treatment with Heparin? ..... Yes: ☐ No: ☐

If yes, please describe: _____

10. Did you have any blood pressure readings or measurements taken at any time during the 24 hours BEFORE OR AFTER the administration of allegedly contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please attach copies of all such readings or measurements (including computer readouts or summaries thereof) in your possession or the possession of your attorneys or other agents or representatives.

11. Has any doctor or health care professional or provider who has ever seen or treated you told you that your symptoms or injuries were caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please state and describe to the best of your recollection:

a. The names of all doctors or health care professionals or providers who told you this:

_____

_____

_____

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b. The date and manner in which all such conversation(s) or communication(s) occurred:

_____

_____

_____

c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

_____

_____

_____

12. In addition to any discussions or communications identified in Question 11 above, have you had any other discussions with any doctor or health care professional or provider who has seen or treated you about whether your symptoms or injuries were caused or not caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please state and describe to the best of your recollection:

a. The names of all doctors or health care professionals or providers with whom you had these discussions:

_____

_____

_____

b. The date and manner in which all such conversation(s) or communication(s) occurred:

_____

_____

_____

c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

_____

_____

_____

PART VIII. DAMAGES

A. Are you claiming any bodily injury as a result of using Heparin? ..... Yes: ☐ No: ☐

If yes, please describe in detail the physical injury(ies) you claim were caused by your use of Heparin: _____

_____

B. When did this/these injury(ies) occur? _____

_____

C. What were you doing immediately before and during the time the injury(ies) occurred? _____

_____

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D. Were you hospitalized for this/these injury(ies)? ..... Yes: ☐ No: ☐

If yes, please provide the following information for each injury requiring hospitalization:

Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)

E. Are you claiming a death was caused by contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please answer the following questions. If no, please proceed to Section F.

1. Was the patient hospitalized at the time of death? ..... Yes: ☐ No: ☐
2. Did the patent die during the same hospital admission during which he or she allegedly received contaminated Heparin? ..... Yes: ☐ No: ☐
3. How long after the patient allegedly received contaminated Heparin did the death occur? _____
4. Was the patient receiving Heparin at the time of death? ..... Yes: ☐ No: ☐

   If no, how long after the cessation of treatment with Heparin did the death occur? _____

   _____
5. What was the cause(s) of patient's death as recorded in the patient's medical chart? _____

   _____
6. What was the cause(s) of the patient's death as recorded in the patient's death certificate? _____

   _____
7. Have you had any discussions with any doctor or health care professional or provider who ever saw or treated the patient about whether the patient's death was caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please state and describe.

   a. The date and manner in which all such conversation(s) or communication(s) occurred:

   _____

   _____

   _____

   b. The names of all doctors or health care professionals or providers with whom you had these discussions:

   _____

   _____

   _____

   c. What was said or communicated to you in each communication by each doctor or health care professional or provider named above:

   _____

   _____

   _____

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F. Do you claim or expect to claim that you lost earnings or suffered impairment of earnings capacity as a result of your use of Heparin? ..... Yes: ☐ No: ☐

If yes, please answer questions 1 through 3 below.

1. Please complete the following information with respect to your employment for the past ten (10) years.

Employer(s)	Address	Type of Business/ Position	Dates of Employment

2. Do you claim you have lost time from work as a result of any condition which you believe was caused by your use of Heparin? ..... Yes: ☐ No: ☐

   If yes, state the total amount of time you have lost from work and the total amount of income you have lost:

   Time: _____ Income: $ _____

3. State your earned income for each of the last five years.

Year	Income
	$
	$
	$
	$
	$

G. Have you paid or incurred any out-of-pocket medical or other expenses which are related to any condition you claim was caused by your use of Heparin and for which you seek recovery in this lawsuit? ..... Yes: ☐ No: ☐

If yes, describe the out-of-pocket expenses and state the amount incurred to date for each such expense:

a. Type of expense: _____

b. Amount incurred: $ _____

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PART IX. FACT WITNESSES

A. Please identify all persons (other than the Medical Providers identified in Parts VII(B)(11)-(12), VIII(E)(7), above) who you believe are likely to possess information concerning the claims you assert in this lawsuit and state each such person's address, relationship to you, and the subject(s) of the information he or she may provide.

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

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PART X. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers, representatives or agents.

A. A copy of all medical records (including diagnostic tests or test results) from any physician, hospital or healthcare provider or facility who treated you for any disease, condition or symptom referred to in your response to questions in Part III and IV.

B. Copies of any documents relating to the use of Heparin, or to any condition you claim is related to the use of Heparin.

C. All blood pressure readings or measurements taken within the 24 hours BEFORE OR AFTER the administration of allegedly contaminated Heparin.

D. To the extent not included in the foregoing, all records (including diagnostic tests or test results) relating to any examination by a physician or other healthcare provider, conducted for any purpose other than psychiatric or psychological evaluation, in the period ten (10) years prior to the date upon which you first used Heparin and continuing to the present.

E. If you have been the claimant in or subject of any worker's compensation, Social Security or other disability proceeding, provide copies of all documents relating to such proceeding.

F. If a death is alleged, please provide a copy of the patient's death certificate and autopsy report (if applicable).

G. If you are bringing this lawsuit as an authorized legal representative of a person who used Heparin, including as an administrator, executor or representative of the estate of a deceased patient, please provide copies of all documents establishing your authority to act in such a representative capacity.

H. For each and every healthcare provider, entity or facility identified in Exhibit A, provide an **ORIGINAL SIGNED** authorization for the release of records in the form appended hereto as Exhibit B.

I. If you claim you have suffered a loss of earnings or earning capacity, provide copies of your state and federal tax returns or other documentary evidence demonstrating your earning capacity (such as W-2s, 1099s, etc.) for each of the last five (5) years.

J. If you claim any loss from medical expenses, or other out-of-pocket expenses, provide copies of all bills or invoices.

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PART XI. DECLARATION THAT INFORMATION IS TRUE AND ACCURATE

The information provided in this Fact Sheet must be accurate and true. This Fact Sheet is an official court document that may be used as evidence in any legal proceeding regarding your Claim.

TO BE COMPLETED BY THE INJURED PERSON OR PLAINTIFF:

I declare under the penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information attached as Exhibit A hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part X of this Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers or other agents, and that I have supplied the authorizations for the release of records attached as Exhibit B to this Fact Sheet.

_____ _____

Signature Date

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EXHIBIT A

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IS UNDER A CONTINUING OBLIGATION TO UPDATE AND/OR AMEND THIS FORM AS NEW OR DIFFERENT INFORMATION IS LEARNED OR DEVELOPED.

A. For your current family and/or primary care physician provide the following information:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Approx. Dates of Care: _____

B. Provide the following information for each **primary care physician, family or general practitioner, and internal medicine physician** who has seen or treated you over the ten (10) years before your Heparin injury to the present (excluding the current family and/or primary health care physician listed in A above):

Name	Address	Approximate date(s) of treatment

C. Provide the following information for each **nephrologist and other kidney or dialysis specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

D. Provide the following information for each **endocrinologist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

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E. Provide the following information for each **allergist, immunologist, and ear, nose and throat (ENT) specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

F. Provide the following information for each **cardiologist and heart or chest surgeon** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

G. For any **other physician or healthcare provider** (other than physicians providing psychiatric, psychotherapy, or psychological treatment) who has treated or seen you over the five (5) years before your Heparin injury to the present (who has not already been identified above), provide the following information:

Name	Address	Approximate date(s) of treatment	Reason(s) for treatment

H. Identify each **hospital, clinic and healthcare facility** where you were treated (in-patient, out-patient or emergency room visit) for the five (5) years before your Heparin injury to the present:

Name	Address	Treatment date(s)	Reason(s) for treatment

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I. Identify each **pharmacy, drugstore and other facility** that has dispensed medication to you for the five (5) years before your Heparin injury to the present:

Name of Pharmacy	Address of Pharmacy	Approximate Dates/Years You Used Pharmacy

J. **<u>If but only if</u>** you claim that you suffered psychiatric, psychological or emotional injuries as a result of taking Heparin, list each **psychiatrist, psychologist and/or social worker** from whom you have received treatment during the five years before your Heparin injury to the present and provide the following information:

Name	Address	Approximate date(s) of treatment	Psychiatric, psychological, or emotional condition(s)

K. Provide the following information for each entity or organization that has provided you with **medical or health insurance** over the last ten (10) years.

Insurance Company	Address	Approximate date(s) of coverage	Policy type and number

L. If you have submitted a claim for **social security disability benefits** in the five (5) years before your Heparin injury to the present, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

M. If you have submitted a claim for **workers compensation**, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

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EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:

Patient Name: DOB: SSN:

I, _____, hereby authorize you to release and furnish to: MRC Medical Research Consultants copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, X-rays, CT scans, MRI films, MRA films, echocardiographic recordings, photographs, bone scans or images or recordings of any kind, pathology/cytology/histology/autopsy/ immunohistochemistry specimens or slides, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* All employment records, wage records, insurance records, Medicaid, Medicare, and disability records.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name (plaintiff/representative): _____

Signature: _____ Date: _____

New Document

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

IN RE: HEPARIN PRODUCTS LIABILITY LITIGATION	)	MDL Docket No. 1953
	)	Chief Judge James G. Carr
THIS DOCUMENT RELATES TO MDL DOCKET NO. 1953	)	
PLAINTIFF: _____ NAME(S)	)	

HEPARIN PLAINTIFF FACT SHEET: CARDIAC PROCEDURE

If you believe you were administered contaminated Heparin during a CARDIAC PROCEDURE, please COMPLETE THIS FACT SHEET.

In completing this Fact Sheet, you are under oath and must provide information that is true and accurate to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this Fact Sheet. If you are completing the Fact Sheet as the authorized legal representative on behalf of the person who received contaminated Heparin, please answer the questions as completely as you can for that person.

Please attach as many additional sheets of paper as necessary to fully complete each question on this Fact Sheet.

PART I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____
2. MDL Civil Action No.: _____

[Please Note: If you are completing this Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Heparin. Those questions using the term "You" refer to the person who used Heparin. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

B. Claim Information:

1. Name, address, telephone number, fax number and e-mail address of the principal attorney representing you in this lawsuit:

Name: _____
Firm: _____
Street Address: _____
City, State, and Zip Code: _____
Telephone Number: _____
Fax Number: _____
E-mail Address: _____

THE REST OF THIS FACT SHEET REQUIRES INFORMATION ABOUT THE PERSON WHO USED HEPARIN.

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PART II. PERSONAL INFORMATION

A. Identifying Information:

1. _____ _____ _____
   Last Name First Name Middle Name

2. Maiden or other names used or by which you have been known: _____

3. Current Address:

   Street Address: _____

   City, State, and Zip Code: _____

4. Current or Last Employer:

   Name: _____

   Street Address: _____

   City, State, and Zip Code: _____

   Dates of Employment: _____

   Occupation: _____

5. Social Security Number: _____

6. Date of Birth: Month: _____ Day: _____ Year: _____

7. Sex: Male: ☐ Female: ☐

B. Have you ever filed a worker's compensation claim; social security disability claim; or a lawsuit, other than the present suit, relating to any bodily injury? ..... Yes: ☐ No: ☐

If yes, for each such claim please state:

Type of claim filed (e.g., worker's compensation, social security, etc.): _____

Date claim was filed: _____

Where claim was filed (e.g., court, department, organization, etc.): _____

Claim/docket number, if applicable: _____

Nature of claim/disability: _____

Period of disability: _____

PART III. PLAINTIFF CURRENT MEDICAL CONDITION

A. Is plaintiff deceased? Yes: ☐ No: ☐ If yes, please proceed to Part IV. If no, please answer question III. B-C.

B. Height: _____ Current Weight: _____

C. Do you currently suffer from any of the following diseases or conditions?

1. Hypertension/high blood pressure ..... Yes: ☐ No: ☐
2. Diabetes or metabolic syndrome ..... Yes: ☐ No: ☐
3. Kidney disease or failure ..... Yes: ☐ No: ☐
4. Thyroid disorder ..... Yes: ☐ No: ☐
5. HIV or AIDS ..... Yes: ☐ No: ☐
6. Atherosclerosis ..... Yes: ☐ No: ☐
7. Asthma ..... Yes: ☐ No: ☐
8. Connective tissue or autoimmune disease (including lupus, rheumatoid arthritis, sarcoidosis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
9. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐

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11. Anemia ..... Yes: ☐ No: ☐
12. Arrhythmia ..... Yes: ☐ No: ☐
13. Bleeding or clotting disorders (including hemophilia or Heparin-induced thrombocytopenia (HIT)) ..... Yes: ☐ No: ☐
14. Cancer ..... Yes: ☐ No: ☐
15. Vasculitis ..... Yes: ☐ No: ☐
16. Lung disease (including but not limited to COPD and emphysema) ..... Yes: ☐ No: ☐
17. Other*_____ ..... Yes: ☐ No: ☐

* Please identify any disease(s) or medical condition(s) that require(s) in-patient or out-patient medical care and/or results in continuing or periodic episodes of incapacity.

For each disease or condition identified above, provide the following information:

Injury/Illness/Disability	Approximate Date of Onset	Approximate Date of Diagnosis	Name and Address of First Diagnosing Physician

PART IV. PLAINTIFF MEDICAL BACKGROUND

A. Smoking history: Never smoked cigarettes: ☐ Past smoker of cigarettes: ☐ Current smoker of cigarettes: ☐
If past or current smoker: _____ packs per day for _____ years.

B. Medications

1. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you were taking regularly or periodically WITHIN THE SIX MONTHS BEFORE the date(s) on which you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

2. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you took WITHIN 24 HOURS BEFORE or AFTER the time(s) that you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

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C. To the best of your knowledge, did you ever experience any of the following DURING THE FIVE YEARS BEFORE the injury that forms the basis of your claims in this lawsuit?

1. Shortness of breath not associated with vigorous exercise ..... Yes: ☐ No: ☐
2. Chest tightness ..... Yes: ☐ No: ☐
3. Persistent or recurrent pain in chest ..... Yes: ☐ No: ☐
4. Low blood pressure ..... Yes: ☐ No: ☐
5. Irregular heart beat, including heart palpitations, tachycardia and/or bradycardia ..... Yes: ☐ No: ☐
6. Audible wheezing ..... Yes: ☐ No: ☐
7. Swelling in the mouth or throat or difficulty swallowing ..... Yes: ☐ No: ☐
8. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
9. Swelling in the hands ..... Yes: ☐ No: ☐
10. Numbness or tingling ..... Yes: ☐ No: ☐
11. Generalized or localized sensations of burning or warmth ..... Yes: ☐ No: ☐
12. Dizziness or lightheadedness ..... Yes: ☐ No: ☐
13. Fainting ..... Yes: ☐ No: ☐
14. Chronic nausea, vomiting, or diarrhea ..... Yes: ☐ No: ☐
15. Chronic abdominal pain ..... Yes: ☐ No: ☐
16. Hives or urticaria ..... Yes: ☐ No: ☐
17. Seizures ..... Yes: ☐ No: ☐
18. Skin rashes ..... Yes: ☐ No: ☐
19. Flushing of face or other parts of the body ..... Yes: ☐ No: ☐
20. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐
21. Blurred vision ..... Yes: ☐ No: ☐

D. If you responded yes to any of the above, state the following:

Condition(s)	Approximate Date of Onset	Circumstances Under Which Condition(s) Occurred	Duration of Condition(s)	Name and Address of Physician (if any)

E. To the best of your knowledge, have you ever been told by a doctor or any other health care professional that you have, or may have, or had any of the following:

1. Hypotension or low blood pressure ..... Yes: ☐ No: ☐
2. Hypertension or high blood pressure ..... Yes: ☐ No: ☐
3. Fluctuating blood pressure ..... Yes: ☐ No: ☐
4. Thrombocytopenia or low blood platelet count .... Yes: ☐ No: ☐
5. Heart disease or heart failure ..... Yes: ☐ No: ☐
6. Heart arrhythmia ..... Yes: ☐ No: ☐
7. Atrial fibrillation ..... Yes: ☐ No: ☐
8. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐

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9. Myocardial infarction (heart attack) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐
11. Vascular artery disease ..... Yes: ☐ No: ☐
12. Valvular heart disease ..... Yes: ☐ No: ☐
13. Stroke or transient ischemic attack ..... Yes: ☐ No: ☐
14. Anemia, bleeding, or hemorrhagic disorder ..... Yes: ☐ No: ☐
15. Blood clotting disease or disorder ..... Yes: ☐ No: ☐
16. Seizures ..... Yes: ☐ No: ☐
17. Liver disease (including but not limited to hepatitis) ..... Yes: ☐ No: ☐
18. Diabetes ..... Yes: ☐ No: ☐
19. Adverse reaction to immunization ..... Yes: ☐ No: ☐
20. Hypersensitive or allergic reaction to any drug .... Yes: ☐ No: ☐
21. Hypersensitive or adverse reaction to Heparin ..... Yes: ☐ No: ☐
22. Eczema ..... Yes: ☐ No: ☐
23. Connective tissue or autoimmune disease (including but not limited to lupus, rheumatoid arthritis, sarcoidosis, vasculitis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
24. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
25. Asthma ..... Yes: ☐ No: ☐
26. Lung disease (including but not limited to COPD and emphysema)..... Yes: ☐ No: ☐
27. Pulmonary embolism..... Yes: ☐ No: ☐
28. Superficial or deep venous thrombosis ..... Yes: ☐ No: ☐
29. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐

F. If you responded yes to any of the above, please complete the following:

Condition(s)	Approximate Date of Onset	Name and Address of Physician

G. Have you ever been evaluated or treated by an allergist or immunologist? ..... Yes: ☐ No: ☐
If yes, please provide the following for each allergist or immunologist who has evaluated or treated you:

Name	Address	Approximate Date(s) of Evaluation/Treatment	Reason(s) for Evaluation/Treatment

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H. To the best of your knowledge, have you ever experienced an allergic reaction to any of the following:

1. Food..... Yes: ☐ No: ☐
2. Drugs or medications (including but not limited to antibiotics, anesthesia, and Heparin)..... Yes: ☐ No: ☐
3. Seasonal irritants (e.g., pollens, grass, trees, etc.). Yes: ☐ No: ☐
4. Insects..... Yes: ☐ No: ☐
5. Animals (including animal fur and dander)..... Yes: ☐ No: ☐
6. Mold..... Yes: ☐ No: ☐
7. Dyes..... Yes: ☐ No: ☐
8. Latex..... Yes: ☐ No: ☐
9. Other..... Yes: ☐ No: ☐

I. If you responded yes to any of the above, please complete the following:

Substance	Nature of the Reaction	Approximate Date(s)	Name and Address of Physician (if any)

J. To the best of your knowledge, did you ever receive Heparin prior to the date on which you claim you received contaminated Heparin? ..... Yes: ☐ No: ☐

K. Before your claimed exposure to contaminated Heparin, did you ever suffer an adverse reaction to the administration of Heparin? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

L. Before your claimed exposure to contaminated Heparin, did you ever experience an adverse reaction to a transfusion of blood or any blood product (e.g., plasma)? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

M. Please complete the following information for any surgery that you have had within the past 10 years and for any surgery involving the heart, chest, lungs, amputations, or organ transplants that you have had at ANY TIME.

Type of Surgery	Approximate Date of Surgery	Hospital or Other Surgical Facility	Name and Address of Surgeon

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PART V. FAMILY MEDICAL BACKGROUND

A. Has any parent, sibling or offspring been diagnosed with, experienced or suffered from the following:

1. Adverse reactions to anesthesia ..... Yes: ☐ No: ☐ Don't know: ☐
2. Adverse reactions to immunization ..... Yes: ☐ No: ☐ Don't know: ☐
3. Hypersensitivity/adverse reaction to Heparin ..... Yes: ☐ No: ☐ Don't know: ☐
4. Adverse reactions to dialysis ..... Yes: ☐ No: ☐ Don't know: ☐

B. If you responded yes to any of the above, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Condition Listed Above

C. Has any parent, sibling or offspring had a history of severe allergic reactions requiring hospitalization or injection with epinephrine? ..... Yes: ☐ No: ☐ Don't know: ☐

If yes, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Reaction

PART VI. PRODUCT IDENTIFICATION

A. Do you contend that you have suffered an injury as a result of the administration of contaminated Heparin?..... Yes: ☐ No: ☐

If yes, please provide the following information (if known).

1. Manufacturer: _____
2. Distributor: _____
3. Lot Number: _____
4. Date administered: _____
5. Method of administration: _____
6. Amount administered: _____
7. Physician/clinic: _____

B. If you contend you received contaminated Heparin on more than one occasion, please attach additional sheets as necessary to provide the information for each such occasion.

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PART VII. CARDIAC PROCEDURE AND EXPOSURE TO CONTAMINATED HEPARIN

A. Identify the medical condition or symptoms that led to the cardiac surgery or procedure:

_____

B. Identify the type of cardiac surgery or procedure you were undergoing:

_____

C. Provide the date of the surgery or procedure, the name of the physician performing the surgery or procedure, and the name of the facility where the procedure was performed.

Date of Procedure	Treating Physician	Facility

D. Were you hospitalized prior to the time of surgery or procedure? Yes: ☐ No: ☐

If yes, for how long prior to the surgery or procedure? _____

E. Claimed Exposure and Response to Contaminated Heparin.

1. Date and approximate time that your surgery or procedure began. _____

2. Date and approximate time that you believe you experienced symptoms allegedly related to contaminated Heparin. _____

3. Describe in detail the injuries and symptoms you believe you suffered as a result of administration of contaminated Heparin.

_____
_____
_____
_____
_____

a. How was Heparin administered to you? ..... Intravenously: ☐ Subcutaneously: ☐ Don't know: ☐

b. How soon after administration of the Heparin did you suffer your claimed injuries and symptoms? _____

c. How long did the injuries and symptoms last? _____

d. Was Heparin administration discontinued as a result of your reaction? _____

e. Was the Heparin dose reduced (but not discontinued) or was the infusion rate of the Heparin reduced (but not discontinued)? _____

4. Describe in detail any treatment you received for the injuries and symptoms described in response to Question E.3 above, if any, including any hospitalization.

_____
_____
_____
_____
_____

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5. Were you given any of the following medications to treat the injuries and symptoms experienced after your alleged receipt of contaminated Heparin?

   a. protamine sulfate ..... Yes: ☐ No: ☐ Don't know: ☐
   b. antihistamines ..... Yes: ☐ No: ☐ Don't know: ☐
   c. corticosteroids ..... Yes: ☐ No: ☐ Don't know: ☐
   d. epinephrine ..... Yes: ☐ No: ☐ Don't know: ☐

6. Did you have any blood pressure readings or measurements taken at any time during the 24 hours BEFORE OR AFTER the administration of allegedly contaminated heparin?..... Yes: ☐ No: ☐

   If yes, please attach copies of all such readings or measurements (including computer readouts or summaries thereof) in your possession or the possession of your attorneys or other agents or representatives.

7. Has any doctor or health care professional or provider who has ever seen or treated you told you that your symptoms or injuries were caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please state and describe to the best of your recollection:

   a. The names of all doctors or health care professionals or providers who told you this:

   _____

   _____

   _____

   b. The date and manner in which all such conversation(s) or communication(s) occurred:

   _____

   _____

   _____

   c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

   _____

   _____

   _____

8. In addition to any discussions or communications identified in Question 7 above, have you had any other discussions with any doctor or health care professional or provider who has seen or treated you about whether your symptoms or injuries were caused or not caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please state and describe to the best of your recollection:

   a. The names of all doctors or health care professionals or providers with whom you had these discussions:

   _____

   _____

   _____

   b. The date and manner in which all such conversation(s) or communication(s) occurred:

   _____

   _____

   _____

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c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

_____

_____

_____

PART VIII. DAMAGES

A. Are you claiming any bodily injury as a result of using Heparin?..... Yes: ☐ No: ☐

If yes, please describe in detail the physical injury(ies) you claim were caused by your use of Heparin: _____

_____

B. When did this/these injury(ies) occur? _____

_____

C. What were you doing immediately before and during the time the injury(ies) occurred? _____

_____

D. Were you hospitalized for this/these injury(ies)? ..... Yes: ☐ No: ☐

If yes, please provide the following information for each injury requiring hospitalization:

Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)

E. Are you claiming a death was caused by contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please answer the following questions. If no, please proceed to Section F.

1. Was the patient hospitalized at the time of death? ..... Yes: ☐ No: ☐
2. Did the patent die during the same hospital admission during which he or she allegedly received contaminated Heparin? ..... Yes: ☐ No: ☐
3. How long after the patient allegedly received contaminated Heparin did the death occur? _____
4. Was the patient receiving Heparin at the time of death? ..... Yes: ☐ No: ☐

   If no, how long after the cessation of treatment with Heparin did the death occur? _____

   _____
5. What was the cause(s) of patient's death as recorded in the patient's medical chart? _____

   _____
6. What was the cause(s) of the patient's death as recorded in the patient's death certificate? _____

   _____
7. Have you had any discussions with any doctor or health care professional or provider who ever saw or treated the patient about whether the patient's death was caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

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If yes, please state and describe.

a. The date and manner in which all such conversation(s) or communication(s) occurred:

_____

_____

_____

b. The names of all doctors or health care professionals or providers with whom you had these discussions:

_____

_____

_____

c. What was said or communicated to you in each communication by each doctor or health care professional or provider named above:

_____

_____

_____

F. Do you claim or expect to claim that you lost earnings or suffered impairment of earnings capacity as a result of your use of Heparin? ..... Yes: ☐ No: ☐

If yes, please answer questions 1 through 3 below.

1. Please complete the following information with respect to your employment for the past ten (10) years.

Employer(s)	Address	Type of Business/ Position	Dates of Employment

2. Do you claim you have lost time from work as a result of any condition which you believe was caused by your use of Heparin? ..... Yes: ☐ No: ☐

If yes, state the total amount of time you have lost from work and the total amount of income you have lost:

Time: _____ Income: $ _____

3. State your earned income for each of the last five years.

Year	Income
	$
	$
	$
	$
	$

G. Have you paid or incurred any out-of-pocket medical or other expenses which are related to any condition you claim was caused by your use of Heparin and for which you seek recovery in this lawsuit? ..... Yes: ☐ No: ☐

If yes, describe the out-of-pocket expenses and state the amount incurred to date for each such expense:

a. Type of expense: _____

b. Amount incurred: $ _____

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PART IX. FACT WITNESSES

A. Please identify all persons (other than the Medical Providers identified in Parts VII(E)(7)-(8), VIII(E)(7), above) who you believe are likely to possess information concerning the claims you assert in this lawsuit and state each such person's address, relationship to you, and the subject(s) of the information he or she may provide.

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

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PART X. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers, representatives or agents.

A. A copy of all medical records (including diagnostic tests or test results) from any physician, hospital or healthcare provider or facility who treated you for any disease, condition or symptom referred to in your response to questions in Part III and IV.

B. Copies of any documents relating to the use of Heparin, or to any condition you claim is related to the use of Heparin.

C. All blood pressure readings or measurements taken within the 24 hours BEFORE OR AFTER the administration of allegedly contaminated Heparin.

D. To the extent not included in the foregoing, all records (including diagnostic tests or test results) relating to any examination by a physician or other healthcare provider, conducted for any purpose other than psychiatric or psychological evaluation, in the period ten (10) years prior to the date upon which you first used Heparin and continuing to the present.

E. If you have been the claimant in or subject of any worker's compensation, Social Security or other disability proceeding, provide copies of all documents relating to such proceeding.

F. If a death is alleged, please provide a copy of the patient's death certificate and autopsy report (if applicable).

G. If you are bringing this lawsuit as an authorized legal representative of a person who used Heparin, including as an administrator, executor or representative of the estate of a deceased patient, please provide copies of all documents establishing your authority to act in such a representative capacity.

H. For each and every healthcare provider, entity or facility identified in Exhibit A, provide an **ORIGINAL SIGNED** authorization for the release of records in the form appended hereto as Exhibit B.

I. If you claim you have suffered a loss of earnings or earning capacity, provide copies of your state and federal tax returns or other documentary evidence demonstrating your earning capacity (such as W-2s, 1099s, etc.) for each of the last five (5) years.

J. If you claim any loss from medical expenses, or other out-of-pocket expenses, provide copies of all bills or invoices.

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PART XI. DECLARATION THAT INFORMATION IS TRUE AND ACCURATE

The information provided in this Fact Sheet must be accurate and true. This Fact Sheet is an official court document that may be used as evidence in any legal proceeding regarding your Claim.

TO BE COMPLETED BY THE INJURED PERSON OR PLAINTIFF:

I declare under the penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information attached as Exhibit A hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part X of this Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers or other agents, and that I have supplied the authorizations for the release of records attached as Exhibit B to this Fact Sheet.

_____ _____

Signature Date

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EXHIBIT A

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IS UNDER A CONTINUING OBLIGATION TO UPDATE AND/OR AMEND THIS FORM AS NEW OR DIFFERENT INFORMATION IS LEARNED OR DEVELOPED.

A. For your current family and/or primary care physician provide the following information:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Approx. Dates of Care: _____

B. Provide the following information for each **primary care physician, family or general practitioner, and internal medicine physician** who has seen or treated you over the ten (10) years before your Heparin injury to the present (excluding the current family and/or primary health care physician listed in A above):

Name	Address	Approximate date(s) of treatment

C. Provide the following information for each **nephrologist and other kidney or dialysis specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

D. Provide the following information for each **endocrinologist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

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E. Provide the following information for each **allergist, immunologist, and ear, nose and throat (ENT) specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

F. Provide the following information for each **cardiologist and heart or chest surgeon** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

G. For any **other physician or healthcare provider** (other than physicians providing psychiatric, psychotherapy, or psychological treatment) who has treated or seen you over the five (5) years before your Heparin injury to the present (who has not already been identified above), provide the following information:

Name	Address	Approximate date(s) of treatment	Reason(s) for treatment

H. Identify each **hospital, clinic and healthcare facility** where you were treated (in-patient, out-patient or emergency room visit) for the five (5) years before your Heparin injury to the present:

Name	Address	Treatment date(s)	Reason(s) for treatment

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I. Identify each **pharmacy, drugstore and other facility** that has dispensed medication to you for the five (5) years before your Heparin injury to the present:

Name of Pharmacy	Address of Pharmacy	Approximate Dates/Years You Used Pharmacy

J. **If but only if** you claim that you suffered psychiatric, psychological or emotional injuries as a result of taking Heparin, list each **psychiatrist, psychologist and/or social worker** from whom you have received treatment during the five years before your Heparin injury to the present and provide the following information:

Name	Address	Approximate date(s) of treatment	Psychiatric, psychological, or emotional condition(s)

K. Provide the following information for each entity or organization that has provided you with **medical or health insurance** over the last ten (10) years.

Insurance Company	Address	Approximate date(s) of coverage	Policy type and number

L. If you have submitted a claim for **social security disability benefits** in the five (5) years before your Heparin injury to the present, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

M. If you have submitted a claim for **workers compensation**, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

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EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:

Patient Name: DOB: SSN:

I, _____, hereby authorize you to release and furnish to: MRC Medical Research Consultants copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, X-rays, CT scans, MRI films, MRA films, echocardiographic recordings, photographs, bone scans or images or recordings of any kind, pathology/cytology/histology/autopsy/ immunohistochemistry specimens or slides, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* All employment records, wage records, insurance records, Medicaid, Medicare, and disability records.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name (plaintiff/representative): _____

Signature: _____ Date: _____

New Document

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
WESTERN DIVISION

IN RE: HEPARIN PRODUCTS LIABILITY LITIGATION	)	MDL Docket No. 1953
	)	Chief Judge James G. Carr
THIS DOCUMENT RELATES TO MDL DOCKET NO. 1953	)	
PLAINTIFF: _____	)	
NAME(S)	)	

HEPARIN PLAINTIFF FACT SHEET: OTHER PROCEDURE

If you believe you were administered contaminated Heparin during a MEDICAL PROCEDURE UNRELATED to KIDNEY DIALYSIS or CARDIAC PROCEDURE, please COMPLETE THIS FACT SHEET.

In completing this Fact Sheet, you are under oath and must provide information that is true and accurate to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You may and should consult with your attorney if you have any questions regarding the completion of this Fact Sheet. If you are completing the Fact Sheet as the authorized legal representative on behalf of the person who received contaminated Heparin, please answer the questions as completely as you can for that person.

Please attach as many additional sheets of paper as necessary to fully complete each question on this Fact Sheet.

PART I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____
2. MDL Civil Action No.: _____

[Please Note: If you are completing this Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who used Heparin. Those questions using the term "You" refer to the person who used Heparin. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

B. Claim Information:

1. Name, address, telephone number, fax number and e-mail address of the principal attorney representing you in this lawsuit:

Name: _____

Firm: _____

Street Address: _____

City, State, and Zip Code: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

THE REST OF THIS FACT SHEET REQUIRES INFORMATION ABOUT THE PERSON WHO USED HEPARIN.

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PART II. PERSONAL INFORMATION

A. Identifying Information:

1. _____ _____ _____
   Last Name First Name Middle Name

2. Maiden or other names used or by which you have been known: _____

3. Current Address:

   Street Address: _____

   City, State, and Zip Code: _____

4. Current or Last Employer:

   Name: _____

   Street Address: _____

   City, State, and Zip Code: _____

   Dates of Employment: _____

   Occupation: _____

5. Social Security Number: _____

6. Date of Birth: Month: _____ Day: _____ Year: _____

7. Sex: Male: ☐ Female: ☐

B. Have you ever filed a worker's compensation claim; social security disability claim; or a lawsuit, other than the present suit, relating to any bodily injury? ..... Yes: ☐ No: ☐

If yes, for each such claim please state:

Type of claim filed (e.g., worker's compensation, social security, etc.): _____

Date claim was filed: _____

Where claim was filed (e.g., court, department, organization, etc.): _____

Claim/docket number, if applicable: _____

Nature of claim/disability: _____

Period of disability: _____

PART III. PLAINTIFF CURRENT MEDICAL CONDITION

A. Is plaintiff deceased? Yes: ☐ No: ☐ If yes, please proceed to Part IV. If no, please answer question III. B-C.

B. Height: _____ Current Weight: _____

C. Do you currently suffer from any of the following diseases or conditions?

1. Hypertension/high blood pressure ..... Yes: ☐ No: ☐
2. Diabetes or metabolic syndrome ..... Yes: ☐ No: ☐
3. Kidney disease or failure ..... Yes: ☐ No: ☐
4. Thyroid disorder ..... Yes: ☐ No: ☐
5. HIV or AIDS ..... Yes: ☐ No: ☐
6. Atherosclerosis ..... Yes: ☐ No: ☐
7. Asthma ..... Yes: ☐ No: ☐
8. Connective tissue or autoimmune disease (including lupus, rheumatoid arthritis, sarcoidosis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
9. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐

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11. Anemia ..... Yes: ☐ No: ☐
12. Arrhythmia ..... Yes: ☐ No: ☐
13. Bleeding or clotting disorders (including hemophilia or Heparin-induced thrombocytopenia (HIT)) ..... Yes: ☐ No: ☐
14. Cancer ..... Yes: ☐ No: ☐
15. Vasculitis ..... Yes: ☐ No: ☐
16. Lung disease (including but not limited to COPD and emphysema) ..... Yes: ☐ No: ☐
17. Other*_____ ..... Yes: ☐ No: ☐

    * Please identify any other disease(s) or medical condition(s) that require(s) in-patient or out-patient medical care and/or results in continuing or periodic episodes of incapacity.

For each disease or condition identified above, provide the following information:

Injury/Illness/Disability	Approximate Date of Onset	Approximate Date of Diagnosis	Name and Address of First Diagnosing Physician

PART IV. PLAINTIFF MEDICAL BACKGROUND

A. Smoking history: Never smoked cigarettes: ☐ Past smoker of cigarettes: ☐ Current smoker of cigarettes: ☐
If past or current smoker: _____ packs per day for _____ years.

B. Medications

1. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you were taking regularly or periodically WITHIN THE SIX MONTHS BEFORE the date(s) on which you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

2. List all medications (including prescription, over-the-counter, "alternative", vitamins, and food supplements) you took WITHIN 24 HOURS BEFORE or AFTER the time(s) that you claim you were administered contaminated Heparin, including but not limited to blood pressure (antihypertensive) medications and antibiotics.

Name of Medication	Dosage	Frequency (e.g., 1 x day)

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C. To the best of your knowledge, did you ever experience any of the following DURING THE FIVE YEARS BEFORE the injury that forms the basis of your claims in this lawsuit?

1. Shortness of breath not associated with vigorous exercise ..... Yes: ☐ No: ☐
2. Chest tightness ..... Yes: ☐ No: ☐
3. Persistent or recurrent pain in chest ..... Yes: ☐ No: ☐
4. Low blood pressure ..... Yes: ☐ No: ☐
5. Irregular heart beat, including heart palpitations, tachycardia and/or bradycardia ..... Yes: ☐ No: ☐
6. Audible wheezing ..... Yes: ☐ No: ☐
7. Swelling in the mouth or throat or difficulty swallowing ..... Yes: ☐ No: ☐
8. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
9. Swelling in the hands ..... Yes: ☐ No: ☐
10. Numbness or tingling ..... Yes: ☐ No: ☐
11. Generalized or localized sensations of burning or warmth ..... Yes: ☐ No: ☐
12. Dizziness or lightheadedness ..... Yes: ☐ No: ☐
13. Fainting ..... Yes: ☐ No: ☐
14. Chronic nausea, vomiting, or diarrhea ..... Yes: ☐ No: ☐
15. Chronic abdominal pain ..... Yes: ☐ No: ☐
16. Hives or urticaria ..... Yes: ☐ No: ☐
17. Seizures ..... Yes: ☐ No: ☐
18. Skin rashes ..... Yes: ☐ No: ☐
19. Flushing of face or other parts of the body ..... Yes: ☐ No: ☐
20. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐
21. Blurred vision ..... Yes: ☐ No: ☐

D. If you responded yes to any of the above, state the following:

Condition(s)	Approximate Date of Onset	Circumstances Under Which Condition(s) Occurred	Duration of Condition(s)	Name and Address of Physician (if any)

E. To the best of your knowledge, have you ever been told by a doctor or any other health care professional that you have, or may have, or had any of the following:

1. Hypotension or low blood pressure ..... Yes: ☐ No: ☐
2. Hypertension or high blood pressure ..... Yes: ☐ No: ☐
3. Fluctuating blood pressure ..... Yes: ☐ No: ☐
4. Thrombocytopenia or low blood platelet count .... Yes: ☐ No: ☐
5. Heart disease or heart failure ..... Yes: ☐ No: ☐
6. Heart arrhythmia ..... Yes: ☐ No: ☐
7. Atrial fibrillation ..... Yes: ☐ No: ☐
8. Congestive heart failure (CHF) ..... Yes: ☐ No: ☐

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9. Myocardial infarction (heart attack) ..... Yes: ☐ No: ☐
10. Coronary artery disease (CAD) ..... Yes: ☐ No: ☐
11. Vascular artery disease ..... Yes: ☐ No: ☐
12. Valvular heart disease ..... Yes: ☐ No: ☐
13. Stroke or transient ischemic attack ..... Yes: ☐ No: ☐
14. Anemia, bleeding, or hemorrhagic disorder ..... Yes: ☐ No: ☐
15. Blood clotting disease or disorder ..... Yes: ☐ No: ☐
16. Seizures ..... Yes: ☐ No: ☐
17. Liver disease (including but not limited to hepatitis) ..... Yes: ☐ No: ☐
18. Diabetes ..... Yes: ☐ No: ☐
19. Adverse reaction to immunization ..... Yes: ☐ No: ☐
20. Hypersensitive or allergic reaction to any drug .... Yes: ☐ No: ☐
21. Hypersensitive or adverse reaction to Heparin ..... Yes: ☐ No: ☐
22. Eczema ..... Yes: ☐ No: ☐
23. Connective tissue or autoimmune disease (including but not limited to lupus, rheumatoid arthritis, sarcoidosis, vasculitis, scleroderma, and collagen vascular disease) ..... Yes: ☐ No: ☐
24. Angioedema (swelling of the lips, tongue, or eyelids) ..... Yes: ☐ No: ☐
25. Asthma ..... Yes: ☐ No: ☐
26. Lung disease (including but not limited to COPD and emphysema)..... Yes: ☐ No: ☐
27. Pulmonary embolism..... Yes: ☐ No: ☐
28. Superficial or deep venous thrombosis ..... Yes: ☐ No: ☐
29. Diaphoresis (excessive sweating) ..... Yes: ☐ No: ☐

F. If you responded yes to any of the above, please complete the following:

Condition(s)	Approximate Date of Onset	Name and Address of Physician

G. Have you ever been evaluated or treated by an allergist or immunologist? ..... Yes: ☐ No: ☐
If yes, please provide the following for each allergist or immunologist who has evaluated or treated you:

Name	Address	Approximate Date(s) of Evaluation/Treatment	Reason(s) for Evaluation/Treatment

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H. To the best of your knowledge, have you ever experienced an allergic reaction to any of the following:

1. Food..... Yes: ☐ No: ☐
2. Drugs or medications (including but not limited to antibiotics, anesthesia, and Heparin)..... Yes: ☐ No: ☐
3. Seasonal irritants (e.g., pollens, grass, trees, etc.). Yes: ☐ No: ☐
4. Insects..... Yes: ☐ No: ☐
5. Animals (including animal fur and dander)..... Yes: ☐ No: ☐
6. Mold..... Yes: ☐ No: ☐
7. Dyes..... Yes: ☐ No: ☐
8. Latex..... Yes: ☐ No: ☐
9. Other..... Yes: ☐ No: ☐

I. If you responded yes to any of the above, please complete the following:

Substance	Nature of the Reaction	Approximate Date(s)	Name and Address of Physician (if any)

J. To the best of your knowledge, did you ever receive Heparin prior to the date on which you claim you received contaminated Heparin? ..... Yes: ☐ No: ☐

K. Before your claimed exposure to contaminated Heparin, did you ever suffer an adverse reaction to the administration of Heparin? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

L. Before your claimed exposure to contaminated Heparin, did you ever experience an adverse reaction to a transfusion of blood or any blood product (e.g., plasma)? ..... Yes: ☐ No: ☐

If you responded yes, please complete the following:

Reaction(s)	Approximate Date(s) of Reaction(s)	Duration of Reaction(s)	Name and Address of Physician

M. Please complete the following information for any surgery that you have had within the past 10 years and for any surgery involving the heart, chest, lungs, amputations, or organ transplants that you have had at ANY TIME.

Type of Surgery	Approximate Date of Surgery	Hospital or Other Surgical Facility	Name and Address of Surgeon

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PART V. FAMILY MEDICAL BACKGROUND

A. Has any parent, sibling or offspring been diagnosed with, experienced or suffered from the following:

1. Adverse reactions to anesthesia ..... Yes: ☐ No: ☐ Don't know: ☐
2. Adverse reactions to immunization ..... Yes: ☐ No: ☐ Don't know: ☐
3. Hypersensitivity/adverse reaction to Heparin ..... Yes: ☐ No: ☐ Don't know: ☐
4. Adverse reactions to dialysis ..... Yes: ☐ No: ☐ Don't know: ☐

B. If you responded yes to any of the above, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Condition Listed Above

C. Has any parent, sibling or offspring had a history of severe allergic reactions requiring hospitalization or injection with epinephrine? ..... Yes: ☐ No: ☐ Don't know: ☐

If yes, please provide the following:

Relationship	Current Age (or Age at Death)	Type of Reaction

PART VI. PRODUCT IDENTIFICATION

A. Do you contend that you have suffered an injury as a result of the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please provide the following information (if known).

1. Manufacturer: _____
2. Distributor: _____
3. Lot Number: _____
4. Date administered: _____
5. Method of administration: _____
6. Amount administered: _____
7. Physician/clinic: _____

B. If you contend you received contaminated Heparin on more than one occasion, please attach additional sheets as necessary to provide the information for each such occasion.

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PART VII. OTHER PROCEDURE AND EXPOSURE TO CONTAMINATED HEPARIN

A. Identify the medical condition or symptoms that led to the surgery or procedure during which you contend you received contaminated Heparin:

_____

B. Identify the type of surgery or procedure you were undergoing:

_____

C. Provide the date of the surgery or procedure, the name of the physician performing the surgery or procedure, and the name of the facility where the procedure was performed.

Date of Procedure	Treating Physician	Facility

D. Were you hospitalized prior to the time of surgery or procedure? Yes: ☐ No: ☐

If yes, for how long prior to the surgery or procedure? _____

E. Claimed Exposure and Response to Contaminated Heparin.

1. Date and approximate time that your surgery or procedure began. _____
2. Date and approximate time that you believe you experienced symptoms allegedly related to contaminated Heparin. _____
3. Describe in detail the injuries and symptoms you believe you suffered as a result of administration of contaminated Heparin.

_____
_____
_____
_____
_____

a. How was Heparin administered to you? ..... Intravenously: ☐ Subcutaneously: ☐ Don't know: ☐

b. How soon after administration of the Heparin did you suffer your claimed injuries and symptoms? _____

c. How long did the injuries and symptoms last? _____

d. Was Heparin administration discontinued as a result of your reaction? _____

e. Was the Heparin dose reduced (but not discontinued) or was the infusion rate of the Heparin reduced (but not discontinued)? _____

4. Describe in detail any treatment you received for the injuries and symptoms described in response to Question E.3 above, if any, including any hospitalization.

_____
_____
_____
_____
_____

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5. Were you given any of the following medications to treat the injuries and symptoms experienced after your alleged receipt of contaminated Heparin?

   a. protamine sulfate ..... Yes: ☐ No: ☐ Don't know: ☐
   b. antihistamines ..... Yes: ☐ No: ☐ Don't know: ☐
   c. corticosteroids ..... Yes: ☐ No: ☐ Don't know: ☐
   d. epinephrine ..... Yes: ☐ No: ☐ Don't know: ☐

6. Did you have any blood pressure readings or measurements taken at any time during the 24 hours BEFORE OR AFTER the administration of allegedly contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please attach copies of all such readings or measurements (including computer readouts or summaries thereof) in your possession or the possession of your attorneys or other agents or representatives.

7. Has any doctor or health care professional or provider who has ever seen or treated you told you that your symptoms or injuries were caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please state and describe to the best of your recollection:

   a. The names of all doctors or health care professionals or providers who told you this:

   _____

   _____

   _____

   b. The date and manner in which all such conversation(s) or communication(s) occurred:

   _____

   _____

   _____

   c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

   _____

   _____

   _____

8. In addition to any discussions or communications identified in Question 7 above, have you had any other discussions with any doctor or health care professional or provider who has seen or treated you about whether your symptoms or injuries were caused or not caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

   If yes, please state and describe to the best of your recollection:

   a. The names of all doctors or health care professionals or providers with whom you had these discussions:

   _____

   _____

   _____

   b. The date and manner in which all such conversation(s) or communication(s) occurred:

   _____

   _____

   _____

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c. What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:

_____

_____

_____

PART VIII. DAMAGES

A. Are you claiming any bodily injury as a result of using Heparin?..... Yes: ☐ No: ☐

If yes, please describe in detail the physical injury(ies) you claim were caused by your use of Heparin: _____

_____

B. When did this/these injury(ies) occur? _____

_____

C. What were you doing immediately before and during the time the injury(ies) occurred? _____

_____

D. Were you hospitalized for this/these injury(ies)? ..... Yes: ☐ No: ☐

If yes, please provide the following information for each injury requiring hospitalization:

Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)

E. Are you claiming a death was caused by contaminated Heparin? ..... Yes: ☐ No: ☐

If yes, please answer the following questions. If no, please proceed to Section F.

1. Was the patient hospitalized at the time of death? ..... Yes: ☐ No: ☐
2. Did the patent die during the same hospital admission during which he or she allegedly received contaminated Heparin? ..... Yes: ☐ No: ☐
3. How long after the patient allegedly received contaminated Heparin did the death occur? _____
4. Was the patient receiving Heparin at the time of death? ..... Yes: ☐ No: ☐

   If no, how long after the cessation of treatment with Heparin did the death occur? _____

   _____
5. What was the cause(s) of patient's death as recorded in the patient's medical chart? _____

   _____
6. What was the cause(s) of the patient's death as recorded in the patient's death certificate? _____

   _____
7. Have you had any discussions with any doctor or health care professional or provider who ever saw or treated the patient about whether the patient's death was caused by the administration of contaminated Heparin? ..... Yes: ☐ No: ☐

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If yes, please state and describe.

a. The date and manner in which all such conversation(s) or communication(s) occurred:

_____

_____

_____

b. The names of all doctors or health care professionals or providers with whom you had these discussions:

_____

_____

_____

c. What was said or communicated to you in each communication by each doctor or health care professional or provider named above:

_____

_____

_____

F. Do you claim or expect to claim that you lost earnings or suffered impairment of earnings capacity as a result of your use of Heparin? ..... Yes: ☐ No: ☐

If yes, please answer questions 1 through 3 below.

1. Please complete the following information with respect to your employment for the past ten (10) years.

Employer(s)	Address	Type of Business/ Position	Dates of Employment

2. Do you claim you have lost time from work as a result of any condition which you believe was caused by your use of Heparin? ..... Yes: ☐ No: ☐

If yes, state the total amount of time you have lost from work and the total amount of income you have lost:

Time: _____ Income: $ _____

3. State your earned income for each of the last five years.

Year	Income
	$
	$
	$
	$
	$

G. Have you paid or incurred any out-of-pocket medical or other expenses which are related to any condition you claim was caused by your use of Heparin and for which you seek recovery in this lawsuit? ..... Yes: ☐ No: ☐

If yes, describe the out-of-pocket expenses and state the amount incurred to date for each such expense:

a. Type of expense: _____

b. Amount incurred: $ _____

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PART IX. FACT WITNESSES

A. Please identify all persons (other than the Medical Providers identified in Parts VII(E)(7)-(8), VIII(E)(7), above) who you believe are likely to possess information concerning the claims you assert in this lawsuit and state each such person's address, relationship to you, and the subject(s) of the information he or she may provide.

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

Name: _____

Address: _____

_____

Relationship to you: _____

Subject(s) of information: _____

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PART X. DOCUMENTS

Attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers, representatives or agents.

A. A copy of all medical records (including diagnostic tests or test results) from any physician, hospital or healthcare provider or facility who treated you for any disease, condition, or symptom referred to in your response to questions in Part III and IV.

B. Copies of any documents relating to the use of Heparin, or to any condition you claim is related to the use of Heparin.

C. All blood pressure readings or measurements taken within the 24 hours BEFORE OR AFTER the administration of allegedly contaminated Heparin.

D. To the extent not included in the foregoing, all records (including diagnostic tests or test results) relating to any examination by a physician or other healthcare provider, conducted for any purpose other than psychiatric or psychological evaluation, in the period ten (10) years prior to the date upon which you first used Heparin and continuing to the present.

E. If you have been the claimant in or subject of any worker's compensation, Social Security, or other disability proceeding, provide copies of all documents relating to such proceeding.

F. If a death is alleged, please provide a copy of the patient's death certificate and autopsy report (if applicable).

G. If you are bringing this lawsuit as an authorized legal representative of a person who used Heparin, including as an administrator, executor, or representative of the estate of a deceased patient, please provide copies of all documents establishing your authority to act in such a representative capacity.

H. For each and every healthcare provider, entity or facility identified in Exhibit A, provide an **ORIGINAL SIGNED** authorization for the release of records in the form appended hereto as Exhibit B.

I. If you claim you have suffered a loss of earnings or earning capacity, provide copies of your state and federal tax returns or other documentary evidence demonstrating your earning capacity (such as W-2s, 1099s, etc.) for each of the last five (5) years.

J. If you claim any loss from medical expenses, or other out-of-pocket expenses, provide copies of all bills or invoices.

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PART XI. DECLARATION THAT INFORMATION IS TRUE AND ACCURATE

The information provided in this Fact Sheet must be accurate and true. This Fact Sheet is an official court document that may be used as evidence in any legal proceeding regarding your Claim.

TO BE COMPLETED BY THE INJURED PERSON OR PLAINTIFF:

I declare under the penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information attached as Exhibit A hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part X of this Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers or other agents, and that I have supplied the authorizations for the release of records attached as Exhibit B to this Fact Sheet.

_____ _____

Signature Date

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EXHIBIT A

LIST OF MEDICAL PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF IS UNDER A CONTINUING OBLIGATION TO UPDATE AND/OR AMEND THIS FORM AS NEW OR DIFFERENT INFORMATION IS LEARNED OR DEVELOPED.

A. For your current family and/or primary care physician provide the following information:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Approx. Dates of Care: _____

B. Provide the following information for each **primary care physician, family or general practitioner, and internal medicine physician** who has seen or treated you over the ten (10) years before your Heparin injury to the present (excluding the current family and/or primary health care physician listed in A above):

Name	Address	Approximate date(s) of treatment

C. Provide the following information for each **nephrologist and other kidney or dialysis specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

D. Provide the following information for each **endocrinologist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

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E. Provide the following information for each **allergist, immunologist, and ear, nose and throat (ENT) specialist** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

F. Provide the following information for each **cardiologist and heart or chest surgeon** who has ever seen or treated you:

Name	Address	Approximate date(s) of treatment

G. For any **other physician or healthcare provider** (other than physicians providing psychiatric, psychotherapy, or psychological treatment) who has treated or seen you over the five (5) years before your Heparin injury to the present (who has not already been identified above), provide the following information:

Name	Address	Approximate date(s) of treatment	Reason(s) for treatment

H. Identify each **hospital, clinic and healthcare facility** where you were treated (in-patient, out-patient or emergency room visit) for the five (5) years before your Heparin injury to the present:

Name	Address	Treatment date(s)	Reason(s) for treatment

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I. Identify each **pharmacy, drugstore and other facility** that has dispensed medication to you for the five (5) years before your Heparin injury to the present:

Name of Pharmacy	Address of Pharmacy	Approximate Dates/Years You Used Pharmacy

J. **If but only if** you claim that you suffered psychiatric, psychological or emotional injuries as a result of taking Heparin, list each **psychiatrist, psychologist and/or social worker** from whom you have received treatment during the five years before your Heparin injury to the present and provide the following information:

Name	Address	Approximate date(s) of treatment	Psychiatric, psychological, or emotional condition(s)

K. Provide the following information for each entity or organization that has provided you with **medical or health insurance** over the last ten (10) years.

Insurance Company	Address	Approximate date(s) of coverage	Policy type and number

L. If you have submitted a claim for **social security disability benefits** in the five (5) years before your Heparin injury to the present, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

M. If you have submitted a claim for **workers compensation**, state the name and address of the office which is most likely to have records concerning your claim:

Name: _____

Street Address: _____

City, State, Zip Code: _____

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EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:

Patient Name: DOB: SSN:

I, _____, hereby authorize you to release and furnish to: MRC Medical Research Consultants copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, X-rays, CT scans, MRI films, MRA films, echocardiographic recordings, photographs, bone scans or images or recordings of any kind, pathology/cytology/histology/autopsy/ immunohistochemistry specimens or slides, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.
* All employment records, wage records, insurance records, Medicaid, Medicare, and disability records.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name (plaintiff/representative): _____

Signature: _____ Date: _____