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

IN RE: DePUY ORTHOPAEDICS, INC., ASR HIP IMPLANT PRODUCTS

Case No. 1: 10 md 2197

SECOND AMENDED CASE MANAGEMENT ORDER NO. 15

For the cases filed on or before March 4, 2013, Plaintiffs were ordered to complete and serve an ASR Supplemental Plaintiff Disclosure Form, attached as Exhibit A, by March 30, 2013.

For cases filed after March 4, 2013, the ASR Supplemental Plaintiff Disclosure form shall be due on the same date the Plaintiff's Preliminary Disclosure form is required to be served per the terms and deadlines of Amended CMO 5.

Service shall be made on Plaintiffs' Liaison Counsel, Michelle L. Kranz, Zoll, Kranz & Borgess LLC, by sending it electronically by email to PServiceofPPD@toledolaw.com, and on Defendants' Liaison Counsel Kristen L. Mayer, Tucker Ellis LLP, by sending it electronically by email to DserviceofPPD@tuckerellis.com.

Each Plaintiff is required to provide, with the Supplemental Disclosure Form, authorization for the release of medical records for medical providers identified in the ASR Supplemental Plaintiff Disclosure Form if authorization for those providers have not been previously provided in response to a Plaintiff Fact Sheet. The authorization for release of medical records to be utilized is attached hereto as Exhibit B.

This ASR Supplemental Plaintiff Disclosure Form must be completed and served regardless of whether a Plaintiff has previously served a Plaintiff Preliminary Disclosure Form or a Plaintiff Fact Sheet – it is a separate and independent form and must be completed. This Form is

not a verified discovery response and is not evidence, but is designed to obtain information the Court finds necessary to assess the need for future discovery. DO NOT FILE THIS FORM WITH THE COURT.

All Plaintiffs have a continuing duty to serve an updated form.

S/ *David A. Katz*
DAVID A. KATZ
U. S. DISTRICT JUDGE

ASR SUPPLEMENTAL PLAINTIFF DISCLOSURE FORM
DO NOT FILE THIS FORM WITH THE COURT

1. (a) Name _____
First Middle Last

(b) DOB: _____
(Please format as MM/DD/YYYY)

(c) Address _____
Street

_____ _____ _____
City State (Abbreviation) Zip Code

(d) Venue: _____
(Please list two letter state abbreviation, followed by judicial district and division.)

(e) Attorney: _____

2. Have you had an ASR hip implant? Yes ___ No ___. (Please mark one response with X.). Have you had an ASR hip implant for both hips? Yes ___ No ___. (Please mark one response with X.) If yes, please answer No. 2 for both sides.

(a) Implant Date (Left): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

(b) Implant Date (Right): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

3. Have you had a revision on either side? Yes ___ No ___. (Please mark one response with X). If yes, please answer No. 3.If you had a bilateral, answer No. 3 for both sides. Revision date is the date you had a second surgery on the hip with the ASR implant.

(a) Revision Date (Left): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____

First Middle Last

(b) Revision Date (Right): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

4. If you have not had a revision yet, but one is scheduled, provide the date: _____(DATE)
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

5. Has your doctor recommended a revision or re-revision, but also advised you that this surgery is medically contraindicated and/or would be life threatening? Yes ___ No ___ (Please mark one response with X.)

If so, identify the name and address of the doctor, the date of the discussion, and the medical condition which prevents you from having the surgery and state whether you have been advised that this condition will permanently prevent you from having revision surgery, as opposed to delaying a revision surgery.

Date(s) of Discussion: _____
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

Doctor _____
First Middle Last

Address _____
Street

_____ _____ _____
City State (Abbreviation) Zip Code

Medical condition: _____
(Please use semi colon to separate distinct medical conditions.)

Medical Condition Permanently Prevents Revision? Yes ___ No ___ (Please mark one response with X.)

6. Do you claim that your **revision surgery** led to any of the following: Yes ___ No ___ (Please mark one response with X.)
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

(a) A second revision _____ (DATE)

(b) A third revision _____ (DATE)

(c) A fourth revision _____ (DATE)

(d) Death _____ (DATE)

(e) Heart Attack _____ (DATE)

(f) Stroke _____ (DATE)

(g) Pulmonary Embolism _____ (DATE)

(h) Deep Vein Thrombosis _____ (DATE)

(i) Dislocation: Yes ___ No ___ (Please mark one response with X.) Number of Dislocations: _____

Please provide the DATE(S) of any dislocations: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon. For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

(j) Infection(s): Yes ___ No ___ (Please mark one response with X.)

Please provide the DATE(S) of any infections: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon. For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

If you marked yes for infection, please mark an X for any and all of the following treatment received:

IV antibiotic treatment ___ Antibiotic spacers ___ Irrigation & Debridement ___

(k) Permanent and Full Time use of a wheel chair or walker for ambulation (not used prior to revision surgery)

Yes ___ No ___ (Please mark one response with X.)

(l) Foot drop: Yes ___ No ___ (Please mark one response with X.)

If you marked yes for foot drop, please identify the treatment received or recommended:

_____

_____

7. Have you had any other hip surgery post-revision (not already identified above) that you claim is related to the revision? Only answer yes if you have undergone surgery. Do not answer yes if you have only received injections.

Yes ___ No ___ (Please mark one response with X.)

Please state the condition treated: _____

_____

Please provide the DATE(S) of any additional surgeries: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon (;). For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

(Do not include in your response to this question any revision surgery where one or more hip implant parts were removed and replaced or any reduction for a dislocation.)

To the extent you have not already provided authorizations with a previously submitted Plaintiff Fact Sheet (PFS), provide signed authorizations for any doctor or medical provider who has treated you for any condition identified in Questions 4, 5, 6 and 7 above.

LIMITED AUTHORIZATION TO DISCLOSE 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: Drinker Biddle & Reath LLP, Tucker Ellis & West LLP, Barnes & Thornburg LLP, Nutter McClennen & Fish LLP, Skadden Arps and/or their duly assigned agents, including Record Trak, 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 doctor's 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, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, 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.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. 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 his 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 indicate 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