# UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF OHIO

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

### **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' 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

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

IN RE: HEPARIN PRODUCTS	) MDL Docket No. 1953
LIABILITY LITIGATION	) Chief Judge James G. Carr
THIS DOCUMENT RELATES TO  MDL DOCKET NO. 1953 PLAINTIFF:  NAME(S)  HEPARIN PLAINTIFF FACT	) ) ) ) ) ) ) ) SHEET: KIDNEY DIALYSIS
please <u>COMPLETE</u> In completing this Fact Sheet, you are under oath and mus	ninated Heparin during <u>KIDNEY DIALYSIS</u> ,  THIS FACT SHEET.  It provide information that is true and accurate to the best of
You may and should consult with your attorney if you	requested, please provide as much information as you can. have any questions regarding the completion of this Fact thorized legal representative on behalf of the person who as completely as you can for that person.
Please attach as many additional sheets of paper as necess	ary to fully complete each question on this Fact Sheet.
	INFORMATION
A. Please state the following for the civil action which yo	11
	11
A. Please state the following for the civil action which yo	11
<ul> <li>A. Please state the following for the civil action which you</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Fact is remaining questions with respect to the person</li> </ul>	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time
<ol> <li>A. Please state the following for the civil action which you</li> <li>Case Caption:         <ol> <li>MDL Civil Action No.:</li> <li>[Please Note: If you are completing this Fact or remaining questions with respect to the person "You" refer to the person who used Heparin. It</li> </ol> </li> </ol>	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time
<ol> <li>A. Please state the following for the civil action which you.</li> <li>Case Caption:         <ol> <li>MDL Civil Action No.:</li> <li>[Please Note: If you are completing this Fact of the remaining questions with respect to the person "You" refer to the person who used Heparin. I immediately prior to his or her death unless a distribution.</li> </ol> </li> <li>B. Claim Information:         <ol> <li>Name, address, telephone number, fax number and this lawsuit:</li> </ol> </li> </ol>	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time
<ol> <li>A. Please state the following for the civil action which you.</li> <li>Case Caption:         <ol> <li>MDL Civil Action No.:</li> <li>[Please Note: If you are completing this Fact of the remaining questions with respect to the person "You" refer to the person who used Heparin. I immediately prior to his or her death unless a distribution.</li> </ol> </li> <li>B. Claim Information:         <ol> <li>Name, address, telephone number, fax number and this lawsuit:</li> </ol> </li> </ol>	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time ifferent time period is specified.]  I e-mail address of the principal attorney representing you in
A. Please state the following for the civil action which you  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Fact is remaining questions with respect to the person "You" refer to the person who used Heparin. I immediately prior to his or her death unless a d.  B. Claim Information:  1. Name, address, telephone number, fax number and this lawsuit:  Name:  Firm:  Street Address:	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time ifferent time period is specified.]  I e-mail address of the principal attorney representing you in
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A. Please state the following for the civil action which you  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Fact is remaining questions with respect to the person "You" refer to the person who used Heparin. I immediately prior to his or her death unless a d.  B. Claim Information:  1. Name, address, telephone number, fax number and this lawsuit:  Name:  Firm:  Street Address:	Sheet in a representative capacity, please respond to the on who used Heparin. Those questions using the term of the individual is deceased, please respond as of the time ifferent time period is specified.]  I e-mail address of the principal attorney representing you in

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

E-mail Address:

# 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:
D		ve you ever filed a worker's compensation claim; social security disability claim; or a lawsuit, other than the
D.		sent suit, relating to any bodily injury?
		ves, 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 p	plaintiff deceased? Yes:   No:   If yes, please proceed to Part IV. If no, please answer question III. B-C.
В.	He	ight:Current Weight:
C.	Do	you currently suffer from any of the following diseases or conditions?
	1.	Hypertension/high blood pressure
	2.	Diabetes or metabolic syndrome
	3.	Kidney disease or failure
	4.	Thyroid disorder
	5.	HIV or AIDS
	6.	Atherosclerosis
	7.	Asthma
	8.	Connective tissue or autoimmune disease
		(including lupus, rheumatoid arthritis, sarcoidosis,
	9.	scleroderma, and collagen vascular disease)
		Coronary artery disease (CAD)
	TU.	Colonely altery absence (Critz) announcement 195.

11. A	Anemia	Yes	: □ No: □	
12. A	Arrhythmia	Yes	: □ No: □	
	Bleeding or clotting disorders (includ			
	emophilia or Heparin-induced thron			
	HIT))			
	Cancer			
	Vasculitis		: □ No: □	
	Lung disease (including but not limit			A
	ind emphysema)			9
	Other*			E)
	'Please identify any other disease(s) equire(s) in-patient or out-patient me	•	` '	60'
	continuing or periodic episodes of inc		results in	AL
each o	disease or condition identified above			
	Injury/Illness/Disability	Approximate Dat of Onset	te Approximate Date Diagnosis	e of Name and Address of First Diagnosing Physician
				0
	PART IV. PI	LAINTIFF MED	ICAL BACKGROU	IND
Medical Medica	st or current smoker: packs per lications List all medications (including presc you were taking regularly or periodical claim you were administered contantihypertensive) medications and an	ription, over-the- cally WITHIN Tontaminated Hepa	HE SIX MONTHS E	BEFORE the date(s) on which yo
Г	Name of Medication		Dosage	Frequency (e.g., 1 x day)
		Y	- B	
L	The state of the s			
	-00			
	10 De			
	List all medications (including preso you took WITHIN 24 HOURS BE	FORE or AFTE	R the time(s) that y	you claim you were administere
C	ontaminated Heparin, including b intibiotics.	ut not limited to	o blood pressure (a	intinypertensive) medications an
C		ut not limited t	o blood pressure (a	Frequency (e.g., 1 x day)
C	ntibiotics.	ut not limited t		*
C	ntibiotics.	ut not limited t		*
C	ntibiotics.	ut not limited t		*
C	ntibiotics.	ut not limited t		*

C.				ou ever experience a of your claims in this	-	following I	URING	THE FIVE YE	ARS
	1.	Shortness of brea	th not associated wi	th vigorous					
		exercise		Yes: □	No: □				
	2.	Chest tightness		Yes: 🗆	No: □				
	3.	Persistent or recu	rrent pain in chest	Yes: □	No: □				
	4.	Low blood pressu	ıre	Yes: □	No: □				
	5.	_	at, including heart por bradycardia	oalpitations, Yes:	No: □				(B)
	6.	Audible wheezing	g	Yes: □	No: □			0	$\mathcal{Y}_{\lambda}$
	7.	_	outh or throat or di	fficulty Yes:	No: □			CITYE OR	
	8.		elling of the lips, to					MA	
				Yes: □	No: □			C. J.	
	9.	Swelling in the ha	ands	Yes: □	No: □		- 4		
	10.	Numbness or ting	gling	Yes: □	No: □		00,		
	11.	Generalized or lo	calized sensations o	of burning or		<	3		
		warmth		Yes: □	No: □	00	>		
	12.	Dizziness or light	theadedness	Yes: □	No: □				
	13.	Fainting		Yes: □	No: □	C.			
	14.	Chronic nausea, v	vomiting, or diarrhe	a Yes: 🗆	No: □				
	15.	Chronic abdomin	al pain	Yes: 🗆	No: □○	3			
	16.	Hives or urticaria		Yes: 🗆	No; □				
	17.	Seizures		Yes: 🗓	No: □				
	18.	Skin rashes		Yes: 🛛	No: □				
	19.	Flushing of face	or other parts of the	bodyYes: □	No: □				
	20.	Diaphoresis (exce	essive sweating)	Yes: 🗆	No: □				
	21.	Blurred vision		Yes: □	No: □				
D.	If y	ou responded yes	to any of the above,	state the following:					
			Approximate	Circumstances Under		Duration		Name and Addre	
	$\vdash$	Condition(s)	Date of Onset	Condition(s) Occur	reu	Condition	n(s)	Physician (if ar	iy)
			200						
			00						
			Cir						
г	т.				1		1.1 0.27 4.7002		pulses diseases
E.			nowledge, have you had any of the follo	ever been told by a	doctor or	any other he	aith care	professional that	you
	1.			Yes:	No: □				
		T Y	_	Yes:	No: □				
	2.								
	3.		-	Yes:					
	4. =	-	_	elet count Yes:	No: □				
	5.			Yes: □	No: □				
	6.			Yes: □	No: □				
	7.			Yes: □	No: □				
	8.	Congestive heart	Tailure (CHF)	Yes: 🗆	No: ⊔				

9.	Myocardial infarction	n (heart attack)	Yes: □	No: □	
10	. Coronary artery disea	ase (CAD)	Yes: □	No: □	
11	. Vascular artery disea	se	Yes: □	No: □	
12	. Valvular heart diseas	e	Yes: 🗆	No: □	
13	. Stroke or transient is	chemic attack	Yes: 🗆	No: □	
14	. Anemia, bleeding, or	hemorrhagic disorder	Yes: 🗆	No: □	
15	. Blood clotting diseas	e or disorder	Yes: □	No: □	
16	. Seizures		Yes: 🗆	No: □	
17	Liver disease (includ hepatitis)	ing but not limited to	Yes: □	No: □	RDY
18	. Diabetes		Yes: 🗆	No: □	A.O.
19	. Adverse reaction to in	mmunization	Yes: □	No: □	
20	. Hypersensitive or all	ergic reaction to any drug.	Yes: □	No: □	
21	. Hypersensitive or adv	verse reaction to Heparin	Yes: □	No: □	
22	. Eczema		Yes: 🗆	No: □	C. J.
23	arthritis, sarcoidosis,	autoimmune disease nited to lupus, rheumatoid vasculitis, scleroderma, an ease)		No: □	TO PROTECTIVE ORDER
24		ng of the lips, tongue, or		6	y .
	•			A 30 3	
				No: 🛛	
26		ing but not limited to COP		Na. D	
27			7	The second control of	
		L	~ 19.7		
		enous thrombosisve sweating)			
	*	ny of the above, please cor			
	Condition(s)	Appro	ximate Date	of Onset	Name and Address of Physician
		~			
		<b>Y</b>			
		nated or treated by an allerge following for each allergis			Yes:  No:  s evaluated or treated you:
	Nama	Address		ximate Date(s) of ation/Treatment	Reason(s) for Evaluation/Treatment
	Name	Audiess	Evalu	andiv i i calillelli	Acason(s) for Evaluation Heatment
	*				

H.	To the best of your knowledge,	, have you ever experi	enced an aller	rgic 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., pol	• ′					
	4. Insects						
	5. Animals (including animal						
	6. Mold				83		
	7. Dyes		Yes: □ No	: <b>□</b>	20K		
	8. Latex		Yes: □ No	: 🗆	OF		
	9. Other		Yes: □ No	: □	18		
I.	If you responded yes to any of	the above, please com	plete the foll	owing:	all la		
	Substance	Nature of the Reaction	n Ap	proximate Date(s)	Name and Address of Physician (if any)		
					90,		
				$O_{\lambda}$			
J.	To the best of your knowledge contaminated Heparin?	e, did you ever receiv	ve Heparin pr	ior to the date on w	which you claim you received Yes:   No:		
K.	Before your claimed exposu administration of Heparin?						
	If you responded yes, please co	No. 200 (200 (200 (200 (200 (200 (200 (200					
	Reaction(s)	Approximate Reaction		Duration of Reaction(s)	Name and Address of Physician		
		a C	N'				
		N. D.					
L.	Before your claimed exposur transfusion of blood or any blo	od product (e.g., plasi	ma)?				
	If you responded yes, please co	implete the following	:				
	Reaction(s)	Approximate Reactio		Duration of Reaction(s)	Name and Address of Physician		
M.	Please complete the following surgery involving the heart, che						
	Type of Surgery	Approximate Date of Surgery	Hamital ar O	ther Surgical Facility	Name and Address of Surgeon		
	1 y pe of Surgery	Date of Surgery	1105pital 01 O	mei Suigicai Pacifity	Traine and Address of Sui geon		

# PART V. FAMILY MEDICAL BACKGROUND

A.	Has any parent, sibling or offspring be	en diagnosed with, experienced or suff	ered from the following:
	1. Adverse reactions to anesthesia	Yes: □ No: □ Don't l	know: □
	2. Adverse reactions to immunization	nYes: 🗆 No: 🗆 Don't l	know: □
	3. Hypersensitivity/adverse reaction	to Heparin Yes: 🗆 No: 🗆 Don't l	know: □
	4. Adverse reactions to dialysis	Yes: □ No: □ Don't l	know: □
B.	If you responded yes to any of the abo	ve, please provide the following:	
	Relationship	Current Age (or Age at Death)	Type of Condition Listed Above
			180
C.	Has any parent, sibling or offspring has with epinephrine?	ad a history of severe allergic reactions	
	If yes, please provide the following:		SE
	Relationship	Current Age (or Age at Death)	Type of Reaction
			,
	PART	Γ VI. PRODUCT IDENTIFICATION	N_
A.	Do you contend that you have suffered Heparin?	l an injury as a result of the administrat	
	If yes, please provide the following in	formation (if known).	
	1. Manufacturer:		
	2. Distributor:	, D	
	3. Lot Number:	<u> </u>	
	4. Date administered:	<i>y</i>	
	5. Method of administration:		
	6. Amount administered:		
	7. Physician/clinic:		
В.	If you contend you received contaminancessary to provide the information f		n, please attach additional sheets as

# PART VII. KIDNEY DIALYSIS

Kio 1.	Iney Disease and Treatment Identify the medical condi	:: tion that caused your kidney	(renal) disease:	
2.		ment you have received for I the dates of each treatment	kidney disease (e.g., hemod	dialysis, peritoneal dialys
		Approximate		/
	Treatment(s)	Date(s) of Treatment	Treating Physician	Hospital or Clinic
				R
				ATE .
3.		transplant or are now or h where the transplant was or	nave ever been on a kidney r is to be performed.	transplant list, identify
4.	Kidney dialysis:		10	*
	T 1	Type of Dialysis (Hamadialysis	Treating or Supervising	
	Dialysis Date(s)	Type of Dialysis (Hemodialysis or Peritoneal Dialysis)	reating or Supervising Physician	Hospital or Clinic
	Biary sis Bate(s)	or remorear Bran, sis)	(2)3	Troopical of Chine
			CON TO SERVICE OF THE PROPERTY	
			× 3	
		ا	12	
		<b>A</b>	7	
			Y	
5.	How frequently were you	having dialysis at the time yo	ou claim you received contar	minated Heparin?
6.	How long were you at dial	ysis sessions at the time you	claim you received contami	nated Heparin?
	4			
_		Wh.	P. 1	
7.	/		etween dialysis sessions at	the time you contend y
	received contaminated He	oamn?		
		,		
8.	During the five years BEF	ORE your claimed exposure	to contaminated Heparin, di	id you experience any of
0.	- 25/21/		HOURS FOLLOWING dia	
	/4 ~//		Yes: 🗆 1	Vo: □
		alyzer		No: □
	A V	=	Yes: □ 1	
		_	Yes: □ 1	
		use agent(s)		No: □
		on		No: □
	<del>-</del>	ccess site		No: 🗆
				No: 🗆
				No: □
		pain in your chest		No: □
	11. Low blood pressure		Yes: □ 1	No: □
	10 T			· T - · · · □
	_	cluding heart palpitations an		No: □

	14. Audible W	neezing	• • • • • • • • • • • • • • • • • • • •		Yes: ⊔	NO:	
	15. Swelling in	n the mouth or	throat or di	fficulty swallowing	Yes: 🗆	No: □	
	16. Angioeder	na (swelling of	the lips, to	ngue or eyelids)	Yes: □	No: □	
					Yes: □		
					Yes: □		
					Yes: □		
					Yes: □		
		_			Yes: □		
	_				Yes: □	NT -	
					Yes: □	No: □	THEORDER
					Yes: □	No: □	Ob
					Yes: □	No: □	By
					Yes: □	No: □	~ O,
					Yes: □	No: □	10
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					Yes: □	No: □	)
		- 1 <del>-</del> 1			Yes: □	No: □	
					Yes: □		
					Yes:		
					Yes:	W.	
		-			Yes: □		
					Yes: □		
					Yes: □		
	37. Dony drain	JII				110.	
9.	If you respond	ed ves to any o	f the above	, please complete th	e following:		
7.	ii you respond	ed yes to any o	I tile above	, prease complete in	e Tonowing.		
Condition/	First Date of	Onset Time	Duration	Frequency of	Response (e.g., give	Physician o	or Hospital or Clinic
Condition/ Reaction	First Date of Occurrence	(e.g., 10	Duration	Occurrence (e.g.,	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10			0
		(e.g., 10 minutes after	Duration	Occurrence (e.g., once, less than 5	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
		(e.g., 10 minutes after dialysis	Duration	Occurrence (e.g., once, less thần 5 times, more than 10	saline, stop treatment,	Dialysis	0
Reaction	Occurrence	(e.g., 10 minutes after dialysis begins)		Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)	saline, stop treatment, stop fluid removal)	Dialysis Administrat	or
Reaction	Occurrence  In addition to t	(e.g., 10 minutes after dialysis begins)	listed in P	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)	saline, stop treatment,	Dialysis Administrat	or
Reaction	Occurrence  In addition to t	(e.g., 10 minutes after dialysis begins)	listed in P	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)	saline, stop treatment, stop fluid removal)	Dialysis Administrat	or
Reaction	Occurrence  In addition to to in connection with the connection wi	(e.g., 10 minutes after dialysis begins)  the medications with your dialy	listed in P	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?	saline, stop treatment, stop fluid removal)  You ever received any	Dialysis Administrat	owing medications
Reaction	In addition to to in connection volume.  1. Antibiotics	(e.g., 10 minutes after dialysis begins)  the medications with your dialy	hsted in P	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?	vou ever received any	Dialysis Administrat  y of the follo	owing medications on't know:
Reaction	In addition to to in connection volume 1. Antibiotics 2. Midodrine	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s	histed in Psis treatmen	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?	vou ever received any  Yes:  Yes:  Yes:	Dialysis Administrat  y of the follo  No:  Do  No:  Do	owing medications  on't know:   on't know:
Reaction	In addition to to in connection volume 1. Antibiotics 2. Midodrine 3. Steroids	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	listed in Psis treatmen	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:	v of the follows:	owing medications  on't know:  on't know:  on't know:  on't know:
Reaction	In addition to to in connection volume 2. Midodrine 3. Steroids 4. Iron	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	listed in Psis treatment	Occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:	No: □ Do	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:
Reaction 10.	In addition to to in connection volume.  1. Antibiotics 2. Midodrine 3. Steroids 4. Iron 5. Erythropoi	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:	No: □ Do	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:
Reaction 10.	In addition to to in connection volume 2. Midodrine 3. Steroids 4. Iron	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:	No:   No:   No:   No:   No:   Do  No:  Do  N	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:
Reaction  10.	In addition to to in connection volume 1. Antibiotics 2. Midodrine 3. Steroids 4. Iron 5. Erythropoi imed Exposure	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine  g Agents (Ito Contami	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen	vou ever received any  Yes: Yes: Yes: Yes: Yes: Yes: Yes: Yes	No:   No:   No:   No:   No:   Do  No:  Do  N	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:
B. Cla	In addition to to in connection volume 2. Midodrine 3. Steroids 4. Iron	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine g Agents (Ito Contami	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen nated Heparin.  lysis treatment bega	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:  The stop fluid removal)	No: Do	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:  on't know:
10.	In addition to to in connection volume 2. Midodrine 3. Steroids 4. Iron	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine g Agents (Ito Contami	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen nated Heparin.  lysis treatment bega	vou ever received any  Yes: Yes: Yes: Yes: Yes: Yes: Yes: Yes	No: Do	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:  on't know:
B. Cla	In addition to to in connection volume 2. Midodrine 3. Steroids 4. Iron	(e.g., 10 minutes after dialysis begins)  the medications with your dialy s (brand name F	ProAmatine g Agents (Ito Contami	occurrence (e.g., once, less than 5 times, more than 10 times, regularly etc.)  art IV above, have ynt?  ESAs) (e.g., Epogen nated Heparin.  lysis treatment bega	vou ever received any  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:  Yes:  The stop fluid removal)	No: Do	owing medications  on't know:  on't know:  on't know:  on't know:  on't know:  on't know:

	. How soon after administration of the Heparin did you suffer your claimed injuries and symptoms?
	. How long did the injuries and symptoms last?
	. Was Heparin administration discontinued as a result of your reaction?
	dentify the person(s) who administered and/or monitored the dialysis session during which you believe you eceived contaminated Heparin.
5.	acility where you believe you received contaminated Heparin.
6.	dentify the type of kidney dialyzer and sterilization used.
	Describe in detail any treatment you received for the injuries and symptoms described in response to Question 3.3 above, if any, including any hospitalization.
	Vere you given any of the following medications to treat the injuries and symptoms experienced after your lleged receipt of contaminated Heparin?
	protamine sulfate
9.	old you experience any change in kidney function following treatment with Heparin?
	f yes, please describe:
	old 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?
	f yes, please attach copies of all such readings or measurements (including computer readouts or summaries nereof) in your possession or the possession of your attorneys or other agents or representatives.
	Ias any doctor or health care professional or provider who has ever seen or treated you told you that you symptoms or injuries were caused by the administration of contaminated Heparin?
	yes, please state and describe to the best of your recollection:
	. 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:
		oth abo	addition to any discussions or communications identified in Question 11 above, have you had any er discussions with any doctor or health care professional or provider who has seen or treated you but whether your symptoms or injuries were caused or not caused by the administration of contaminated parin?
		If y	res, 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:
			60
		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	1 claiming any bodily injury as a result of using Heparin?
		11-77	please describe in detail the physical injury(ies) you claim were caused by your use of Heparin:
В.	Wh	en o	lid this/thèse injury(ies) occur?
C.	Wh	at vi	vere you doing immediately before and during the time the injury(ies) occurred?

	Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)
			n?
0.7		lowing questions. If no, please prized at the time of death?	
2.	Did the patent die duri received contaminated I	ng the same hospital admission	during which he or she allegedly Yes: \( \square\) No: \( \square\)
3.		_ ,	d Heparin did the death occur?
4.			
	If no, how long after the	cessation of treatment with Hepa	rin did the death occur?
5.	What was the cause(s) o	f patient's death as recorded in th	e patient's medical chart?
			2
6.	What was the cause(s) o	f the patient's death as recorded i	n the patient's death certificate?
7.	treated the patient about	ut whether the patient's death	alth care professional or provider who ever saw of was caused by the administration of contaminated Yes:   No:
	If yes, please state and d	escribe.	
	a. The date and manne	r in which all such conversation(s	s) or communication(s) occurred:
		- A	
		2	
		3	
	b. The names of all doo	ctors or health care professionals	or providers with whom you had these discussions:
	b. The names of all do	ctors or health care professionals	or providers with whom you had these discussions:
	b. The names of all do	ctors or health care professionals	or providers with whom you had these discussions:
	PROTE	ommunicated to you in each com	or providers with whom you had these discussions:  munication by each doctor or health care professiona

F.		-	_	you lost earnings or suffere		_
	If y	es, please a	answer questions 1 thro	ugh 3 below.		
	1.	Please con	nplete the following inf	ormation with respect to you	ir employment for the past	ten (10) years.
			Employer(s)	Address	Type of Business/ Position	Dates of Employment
						2
						20k
	2.			from work as a result of any		
		If yes, stat	e the total amount of tin	me you have lost from work	and the total amount of inc	ome you have lost:
		Time	: <u> </u>	Income: \$		\$
	3.	State your	earned income for each	n of the last five years.	ORO	
			Year	Income   \$   \$   \$   \$   \$   \$   \$   \$   \$	Sherrio y	
G.				of-pocket medical or other earin and for which you seek i		
	If y	es, describe	e the out-of-pocket expe	enses and state the amount in	ncurred to date for each suc	h expense:
		a. Type	of expense:			
		b. Amou	nt incurred: \$			
			LOCU!			

# 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

Name:	
Address:	
Relationship to you:	
Subject(s) of information:	.18)
Name:	
Address:	
Relationship to you:	pRO
Subject(s) of information:	
Name:	
Address:	
Relationship to you:	
Subject(s) of information:	
Name:	act Dis.
Address:	200
D. I. dia dia da anno	
Relationship to you: Subject(s) of information:	
oROJEKUJED DOCO	

#### 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.

#### 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.

	-10
Signature	Date
CUMBATI DOCC	
Signature  PROILINITIAN PROCESSION AND ASSESSMENT OF THE PROPERTY OF THE PROPE	

# **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 primar	ry care physician provide the following	g information:
	Name:		OB.
	City, State, Zip Code:		
	Approx. Dates of Care:		- CO
В.	internal medicine physician who ha	for each primary care physician, fa as seen or treated you over the ten (10) nily and/or primary health care physici	years before your Heparin injury to
	Name	Address	Approximate date(s) of treatment
		TEC,	
		ello.	
		ME	
C.	Provide the following information fo seen or treated you:	r each nephrologist and other kidney	or dialysis specialist who has ever
	Name	Address	Approximate date(s) of treatment
	TAR.	11001000	0. 1.041.1101.1
	10 D		
D.	Provide the following information for	r each endocrinologist who has ever so	een or treated you:
4	Name	Address	Approximate date(s) of treatment

				0
				aplin
Provide the following info	ormation for each cardiolog	ist and heart or o	hest surg	rean who has ever seen or
treated you:	rination for each cardiolog	ist and neart or c	nest sur	con that ever seen of
Name	Ad	dress	6	Approximate date(s) of treatment
			PP	
		173	) ′	
		C)		
		TB.		
	r healthcare provider (oth) who has treated or seen you ly been identified above), pro	over the five (5) y	ears befor	e your Heparin injury to the
Name	Address	Approximate d of treatmer		Reason(s) for treatment
	~ OO			
	CITY'			
	Ar			
. Identify each hospital, cl emergency room visit) for t	linic and healthcare facilithe five (5) years before you			
Name	Address	Treatment da	te(s)	Reason(s) for treatment
A CO				
RO				
			_	

E. Provide the following information for each allergist, immunologist, and ear, nose and throat (ENT)

Address

Approximate date(s) of treatment

specialist who has ever seen or treated you:

Name

M A DI		of Discourse	Approximate Dates/Years
Name of Pharmacy	Addres	ss of Pharmacy	You Used Pharmacy
			.0_
			ODE
			S.OF
Heparin, list each psychiat	rist, psychologist and/or	, psychological or emotional is social worker from whom y present and provide the follow	ou have received treatme
Name	Address	Approximate date(s) of treatment	Psychiatric, psychological, emotional condition(s)
		*OF	
Provide the following information insurance over the last ten	- /	rganization that has provided	you with medical or heal
MANUFACTOR STOCK OF THE STOCK O		Approximate date(s)	
Insurance Company	Address	of coverage	Policy type and number
	C		
	E DO		
	(C)		
		ability benefits in the five (5) are office which is most likely	
Name:			
Street Address:			
Street Address:  City, State, Zip Code:  If you have submitted a cla	aim for workers compens		
Street Address:  City, State, Zip Code:  If you have submitted a clamost likely to have records	aim for workers compens concerning your claim:	ation, state the name and ad-	
Street Address:  City, State, Zip Code:  If you have submitted a clamost likely to have records  Name:	aim for workers compens concerning your claim:		dress of the office which

I. Identify each pharmacy, drugstore and other facility that has dispensed medication to you for the five (5)

# **EXHIBIT B**

# <u>LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION</u> (Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:			
Patient Name:		DOB:	SSN:
* All medical record documents, correspon	the following information: ls, including inpatient, outpat dence, test results, statemer	ize you to release and furnish ient, and emergency room treatm ts, questionnaires/histories, offic I records shall include all informations.	ent, all clinical charts, reports, e and handwritten notes, and
* All autopsy, labora catheterization reports * All radiology films recordings, photograph	s, mammograms, myelogram ns, bone scans or images or re	thology, radiology, CT Scan, MRs, X-rays, CT scans, MRI films, I cordings of any kind, pathology/cac catheterization videos/CDs/fil	MRA films, echocardiographic ytology/histology/autopsy/
* All pharmacy/presonable * All billing records in	including all statements, item	C numbers and drug information l zed bills, and insurance records. e records, Medicaid, Medicare, an	
defendants. You care, treatment, matter bearing or permitting such discussing my materials.	are not authorized to discudiagnosis, prognosis, information his or her medical or physodiscussion. Subject to all a dedical history, care, treatm	is being forwarded by, or on use any aspect of the above-name nation revealed by or in the mical condition, unless you receive pplicable legal objections, this ent, diagnosis, prognosis, information my medical or physical conditions.	ned person's medical history, edical records, or any other e an additional authorization restriction does not apply to mation revealed by or in the
2. I understand that the disease, acquired in	the information in my health immunodeficiency syndrome	record may include information r (AIDS), or human immunodefici health services, and treatment for	relating to sexually transmitted ency virus (HIV). It may also
authorization I mu department. I und to this authorizati provides my insu	ist do so in writing and prese erstand the revocation will no on. I understand the revoc	is authorization at any time. I unt my written revocation to the hat apply to information that has alrution will not apply to my insurt a claim under my policy. U	ealth information management eady been released in response rance company when the law
authorization. I n information to be information carrie	eed not sign this form in order used or disclosed as proves with it the potential for a ral confidentiality rules. If I	this health information is volunter to assure treatment. I understided in CFR 164.524. I unden unauthorized re-disclosure and have questions about disclosure of	and I may inspect or copy the rstand that any disclosure of I the information may not be
5. A notarized signat original.	ture is not required. CFR 16	4.508. A copy of this authorizati	on may be used in place of an
Print 1	Name (plaintiff/representative	):	

Signature:

Date: \_\_\_\_\_

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

	) MDL Docket No. 1953
IN RE: HEPARIN PRODUCTS	)
LIABILITY LITIGATION	) Chief Judge James G. Carr
THIS DOCUMENT RELATES TO	)
MDL DOCKET NO. 1953	
PLAINTIFF:	) O
NAME(S)	0,5
	_)
HEPARIN PLAINTIFF FACT	SHEET: CARDIAC PROCEDURE
If you haliave you were administered contami	nated Heparin during a <u>CARDIAC PROCEDURE</u> ,
	E THIS FACT SHEET.
In completing this Fact Sheet, you are under oath and m	oust provide information that is true and accurate to the best of
	s requested, please provide as much information as you can.
	ou have any questions regarding the completion of this Fact
	authorized legal representative on behalf of the person who
received contaminated Heparin, please answer the quest	nons as completely as you can for that person.
Please attach as many additional sheets of paper as nece	ssary to fully complete each question on this Fact Sheet.
	A .
A. Please state the following for the civil action which y  1. Case Caption:	E INFORMATION  /ou filed:
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:	you filed:
<ul> <li>A. Please state the following for the civil action which y</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Facremaining questions with respect to the per</li> </ul>	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin.	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time
<ul> <li>A. Please state the following for the civil action which y</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a</li> <li>B. Claim Information:</li> </ul>	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number a this lawsuit:	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Factemaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number at this lawsuit:  Name:  Name:	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]  nd e-mail address of the principal attorney representing you in
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number at this lawsuit:  Name:  Firm:	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]  nd e-mail address of the principal attorney representing you in
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number at this lawsuit:  Name:  Firm:	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]  nd e-mail address of the principal attorney representing you in
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Facremaining questions with respect to the per "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number at this lawsuit:  Name:  Firm:  Street Address:  City, State, and Zip Code:	t Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]  nd e-mail address of the principal attorney representing you in

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

E-mail Address:

# PART II. PERSONAL INFORMATION

A. Identifying Information:

	1.		5	2.1	w &	16:11
		Last Name		Name		Middle Name
	2.	Maiden or other names used or by which	ch you have beer	n known:		
	3.	Current Address:				
		Street Address:				
		City, State, and Zip Code:				
	4.	Current or Last Employer:				D)
		Name:				Or.
		Street Address:				
		City, State, and Zip Code:				
		Dates of Employment:				
		Occupation:				<b>Y</b>
	5.	Social Security Number:			- 20	
	6.	Date of Birth: Month:	_ Day:	Year: _	-0,x,	
	7.	Sex: Male: □ Female: □				
B.	Har	ve you ever filed a worker's compensa	ation claim: socia	al security disa	ability claim: or a	lawsuit, other than the
	110	present suit, relating to any bodily inju				
	If y	yes, for each such claim please state:		1/1/2,		
		Type of claim filed (e.g., worker's com	npensation, socia	1 security, etc.	):	
		Date claim was filed:		71	-	
		Where claim was filed (e.g., court, dep	oartment, organiz	ation, etc.):		
		Claim/docket number, if applicable:	Ja.			
		Claim/docket number, if applicable:				
		Period of disability:	100			
		PART III. PLAIN	TIFF CUDDEN	T MFDICAL	CONDITION	
Α.	Ta e	plaintiff deceased? Yes:   No:   If y				war quartien III D C
	•				II no, piease ans	wer question III. b-C.
В.	He	ight: Gurrent We	eight:			
C.	Do	you currently suffer from any of the fol	llowing diseases	or conditions?		
	1.	Hypertension/high blood pressure	Yes:	□ No: □		
	2.	Diabetes or metabolic syndrome				
	3.	Kidney disease or failure				
	4.	Thyroid disorder				
	5.	HIV or AIDS				
	6.	Atherosclerosis				
	7.	Asthma		□ No: □		
	8.	Connective tissue or autoimmune disea				
		(including lupus, rheumatoid arthritis, scleroderma, and collagen vascular dis	The second secon	□ No: □		
	9.	Congestive heart failure (CHF)				
		Coronary artery disease (CAD)				

12	. Anemia	Yes: 🗆	No: ⊔	
12.	. Arrhythmia	Yes: 🗆	No: □	
13.	Bleeding or clotting disorders (included the hemophilia or Heparin-induced throm			
	(HIT))		No: □	
14	. Cancer			
	Vasculitis			
			N0. ⊔	
16.	. Lung disease (including but not limite and emphysema)		No: □	0
17				(A)
17.	Other*  * Please identify any disease(s) or m			201
	require(s) in-patient or out-patient me	* *		Ole
	continuing or periodic episodes of inc			
~~~				1
For eac	ch disease or condition identified above	e, provide the follow	1 <del>-</del> 10	Ch
	Injury/Illness/Disability	Approximate Date of Onset	Approximate Date of Diagnosis	Name and Address of First Diagnosing Physician
			_ <	R
			10	
<u> </u>				<u> </u>
	PART IV. PI	LAINTIFF MEDIC	AL BACKGROUND	
A Sm	noking history: Never smoked cigare	ettes: □ Past smoke	r of cioarettes: □ Cu	rrent smoker of cigarettes:
ii. Dii	If past or current smoker: pack		years.	are it similar of eight ettes.
D 14			7	
B. Me	edications			
1				
1.	List all medications (including presc			
1.	you were taking regularly or periodi	cally WITHIN THE	SIX MONTHS BEFO	ORE the date(s) on which you
1.	you were taking regularly or periodic claim you were administered co.	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you
1.	you were taking regularly or periodi	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you
1.	you were taking regularly or periodic claim you were administered co.	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you
1.	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you limited to blood pressure
1.	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you limited to blood pressure
1.	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you limited to blood pressure
1.	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an	cally WITHIN THE ntaminated Heparin	SIX MONTHS BEFO	ORE the date(s) on which you limited to blood pressure
	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an Name of Medication	cally WITHIN THE ntaminated, Heparin ntibiotics.	SIX MONTHS BEFO	ORE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)
2.	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an Name of Medication  List all medications (including prescuence)	cally WITHIN THE ntaminated. Heparin ntibiotics.	SIX MONTHS BEFORE, including but not Dosage	DRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements)
	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an ame of Medication (and Medication	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Dosage  anter, "alternative", vitathe time(s) that you of	DRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered
	you were taking regularly or periodic claim you were administered con (antihypertensive) medications and an Name of Medication  List all medications (including prescuence)	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Dosage  anter, "alternative", vitathe time(s) that you of	DRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered
	you were taking regularly or periodiclaim you were administered containing tensive) medications and an ame of Medication  Name of Medication  List all medications (including preserve you took WITHIN 24 HOURS BE contaminated Heparin, including be	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Dosage  anter, "alternative", vitathe time(s) that you of	DRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered
	Vou were taking regularly or periodic claim you were administered containing you were administered containing present the second of the second	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Inter, "alternative", vit. the time(s) that you colood pressure (antihy	PRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered opertensive) medications and
	Vou were taking regularly or periodic claim you were administered containing you were administered containing present the second of the second	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Inter, "alternative", vit. the time(s) that you colood pressure (antihy	PRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered opertensive) medications and
	Vou were taking regularly or periodic claim you were administered containing you were administered containing present the second of the second	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Inter, "alternative", vit. the time(s) that you colood pressure (antihy	PRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered opertensive) medications and
	Vou were taking regularly or periodic claim you were administered containing you were administered containing present the second of the second	cally WITHIN THE ntaminated. Heparin ntibiotics.	Dosage  Inter, "alternative", vit. the time(s) that you colood pressure (antihy	PRE the date(s) on which you limited to blood pressure  Frequency (e.g., 1 x day)  amins, and food supplements) claim you were administered opertensive) medications and

C.				ou ever experience a of your claims in this	-	following I	URING	THE FIVE YE	ARS
	1.	Shortness of brea	th not associated wi	th vigorous					
		exercise		Yes: □	No: □				
	2.	Chest tightness		Yes: 🗆	No: □				
	3.	Persistent or recu	rrent pain in chest	Yes: □	No: □				
	4.	Low blood pressu	ıre	Yes: □	No: □				
	5.	_	at, including heart por bradycardia	oalpitations, Yes:	No: □				(B)
	6.	Audible wheezing	g	Yes: □	No: □			0	$\mathcal{Y}_{\lambda}$
	7.	_	outh or throat or di	fficulty Yes:	No: □			CITYE OR	
	8.		elling of the lips, to					MA	
				Yes: □	No: □			C. J.	
	9.	Swelling in the ha	ands	Yes: □	No: □		- 4		
	10.	Numbness or ting	gling	Yes: □	No: □		00,		
	11.	Generalized or lo	calized sensations o	of burning or		<	3		
		warmth		Yes: □	No: □	00	>		
	12.	Dizziness or light	theadedness	Yes: □	No: □				
	13.	Fainting		Yes: □	No: □	C.			
	14.	Chronic nausea, v	vomiting, or diarrhe	a Yes: 🗆	No: □				
	15.	Chronic abdomin	al pain	Yes: 🗆	No: □○	3			
	16.	Hives or urticaria		Yes: 🗆	No; □				
	17.	Seizures		Yes: 🗓	No: □				
	18.	Skin rashes		Yes: 🛛	No: □				
	19.	Flushing of face	or other parts of the	bodyYes: □	No: □				
	20.	Diaphoresis (exce	essive sweating)	Yes: 🗆	No: □				
	21.	Blurred vision		Yes: □	No: □				
D.	If y	ou responded yes	to any of the above,	state the following:					
			Approximate	Circumstances Under		Duration		Name and Addre	
	$\vdash$	Condition(s)	Date of Onset	Condition(s) Occur	reu	Condition	n(s)	Physician (if ar	iy)
			200						
			00						
			Cir						
г	т.				1		1.1 0.27 4.7002		pulses diseases
E.			nowledge, have you had any of the follo	ever been told by a	doctor or	any other he	aith care	professional that	you
	1.			Yes:	No: □				
		T Y	_	Yes:	No: □				
	2.								
	3.		-	Yes:					
	4. =	-	_	elet count Yes:	No: □				
	5.			Yes: □	No: □				
	6.			Yes: □	No: □				
	7.			Yes: □	No: □				
	8.	Congestive heart	Tailure (CHF)	Yes: 🗆	No: ⊔				

9.	Myocardial infarction	n (heart attack)	Yes: □	No: □	
10	. Coronary artery disea	ase (CAD)	Yes: 🗆	No: □	
11	. Vascular artery disea	se	Yes: □	No: □	
12	. Valvular heart diseas	e	Yes: 🗆	No: □	
13	. Stroke or transient is	chemic attack	Yes: 🗆	No: □	
14	. Anemia, bleeding, or	hemorrhagic disorder	Yes: 🗆	No: □	
15	. Blood clotting diseas	e or disorder	Yes: □	No: □	
16	. Seizures		Yes: 🗆	No: □	
17	Liver disease (includ hepatitis)	ing but not limited to	Yes: □	No: □	RDY
18	. Diabetes		Yes: 🗆	No: □	A.O.
19	. Adverse reaction to in	mmunization	Yes: □	No: □	
20	. Hypersensitive or all	ergic reaction to any drug.	Yes: □	No: □	
21	. Hypersensitive or adv	verse reaction to Heparin	Yes: □	No: □	
22	. Eczema		Yes: 🗆	No: □	C. J.
23	arthritis, sarcoidosis,	autoimmune disease nited to lupus, rheumatoid vasculitis, scleroderma, an ease)		No: □	TO PROTECTIVE ORDER
24		ng of the lips, tongue, or		6	y .
	•			A 30 3	
				No: 🗆	
26		ing but not limited to COP		Na. D	
27			7	The second control of	
		L	~ 19.7		
		enous thrombosisve sweating)			
	*	ny of the above, please cor			
	Condition(s)	Appro	ximate Date	of Onset	Name and Address of Physician
		~			
		<b>Y</b>			
		nated or treated by an allerge following for each allergis			Yes:  No:  s evaluated or treated you:
	Nama	Address		ximate Date(s) of ation/Treatment	Reason(s) for Evaluation/Treatment
	Name	Audiess	Evalu	andiv i i calillelli	Acason(s) for Evaluation Heatment
	*				

Н. Т	To the best of your knowledge	, have you ever experie	enced an aller	gic reaction to any	of the following:		
1	. Food			: □			
2	<ol><li>Drugs or medications (incl antibiotics, anesthesia, and</li></ol>			: 🗆			
3	3. Seasonal irritants (e.g., pol	llens, grass, trees, etc.)	.Yes: □ No	: 🗆			
4	Insects		Yes: □ No	: 🗆			
5	5. Animals (including animal	fur and dander)	Yes: □ No	: 🗆			
6	5. Mold		Yes: □ No	: 🗆			
7	7. Dyes		Yes: □ No	: 🗆			
8	3. Latex		Yes: □ No	:□	OF		
9	Other		Yes: □ No	: 🗆	A CO		
I. I	f you responded yes to any of	the above, please com	plete the follo	owing:	CILLY.		
	Substance	Nature of the Reaction	1 Apj	proximate Date(s)	Name and Address of Physician (if any)		
				2	0,		
				02			
<b>T</b> 7	F. 41. 1. 4 . 6 1. 1.	41.1		COLORD MARKET	41.4 4.1 4		
J. T	ontaminated Heparin?	e, did you ever receiv	e Heparin pri	or to the date on v	which you claim you receivedYes:   No:		
	Before your claimed exposure to contaminated Heparin, did you ever suffer an adverse reaction to the administration of Heparin?						
I	f you responded yes, please co	20 20 20 20 20 20 20 20 20 20 20 20 20 2		,			
	Reaction(s)	Approximate Reaction		Duration of Reaction(s)	Name and Address of Physician		
		6	J'				
		K D					
L. E		,					
tı	ransfusion of blood or any blo	ood product (e.g., plasn	na)?		ce an adverse reaction to a		
tı		ood product (e.g., plasn	na)?				
tı	ransfusion of blood or any blo	ood product (e.g., plasn	Date(s) of				
tı	ransfusion of blood or any blo	ood product (e.g., plasn omplete the following: Approximate	Date(s) of	Duration of	Yes: □ No: □		
tı	ransfusion of blood or any blo	ood product (e.g., plasn omplete the following: Approximate	Date(s) of	Duration of	Yes: □ No: □		
tı	ransfusion of blood or any blood fyou responded yes, please of Reaction(s)	Approximate Reaction	Date(s) of n(s)	Duration of Reaction(s)	Name and Address of Physician  the past 10 years and for any		
tı	ransfusion of blood or any blood fyou responded yes, please of Reaction(s)  Please complete the following surgery involving the heart, ch	Approximate information for any statest, lungs, amputations	Date(s) of n(s)  urgery that you, or organ trains	Duration of Reaction(s)	Name and Address of Physician  the past 10 years and for any ave had at ANY TIME.		
tı	ransfusion of blood or any blood fyou responded yes, please of Reaction(s)  Please complete the following	Approximate Reaction information for any states, lungs, amputations	Date(s) of n(s)  urgery that you, or organ trains	Duration of Reaction(s)	Name and Address of Physician  the past 10 years and for any		
tı	ransfusion of blood or any blood fyou responded yes, please of Reaction(s)  Please complete the following surgery involving the heart, ch	Approximate information for any statest, lungs, amputations	Date(s) of n(s)  urgery that you, or organ trains	Duration of Reaction(s)	Name and Address of Physician  the past 10 years and for any ave had at ANY TIME.		

# PART V. FAMILY MEDICAL BACKGROUND

A.	Has any parent, sibling or offspring be	een diagnosed with, experienced or suff	ered from the following:
	1. Adverse reactions to anesthesia	Yes:   No:   Don't l	know: □
	2. Adverse reactions to immunization	nYes: 🗆 No: 🗆 Don't l	know: □
	3. Hypersensitivity/adverse reaction	to Heparin Yes:   No:   Don't l	know: □
	4. Adverse reactions to dialysis	Yes: □ No: □ Don't l	know: □
B.	If you responded yes to any of the abo	ve, please provide the following:	
	Relationship	Current Age (or Age at Death)	Type of Condition Listed Above
			183
			- TIM
C.		ad a history of severe allergic reactions	
	If yes, please provide the following:		S. L.
	Relationship	Current Age (or Age at Death)	Type of Reaction
		100	
	PAR	Γ VI. PRODUCT IDENTIFICATION	<u>N</u>
A.		d an injury as a result of the administrat	
	If yes, please provide the following in	formation (if known).	
	1. Manufacturer:		
	2. Distributor:		
	3. Lot Number:		
	4. Date administered:	S. S	
	5. Method of administration:		
	6. Amount administered:		
	7. Physician/clinic:		
В.	If you contend you received contaminancessary to provide the information f	ated Heparin on more than one occasion for each such occasion.	n, please attach additional sheets as

# PART VII. CARDIAC PROCEDURE AND EXPOSURE TO CONTAMINATED HEPARIN

	entify	y the type of cardiac surgery or	procedure you were undergoing:			
Pre		e the date of the surgery or pro name of the facility where the		performing the surgery or procedure, and		
	F	Date of Procedure	Treating Physician	Facility		
				Off.		
W		-	e of surgery or procedure? Yes:	No: □		
	пу	ves, for how long prior to the su	rigery or procedure?			
C1	aime	d Exposure and Response to Co	ontaminated Heparin.	DP.		
1.	Da	te and approximate time that yo	our surgery or procedure began.	- CO 1		
2.		te and approximate time that yo	ou believe you experienced sympto	oms allegedly related to contaminated		
3.		scribe in detail the injuries antaminated Heparin.	and symptoms you believe you	suffered as a result of administration of		
		<u> </u>				
	-					
	a.	How was Heparin administere	ed to you?Intraveno	susly: Subcutaneously: Don't know:		
	b.	How soon after administrati	on of the Heparin did you suff	er your claimed injuries and symptoms?		
	c.	How long did the injuries and	symptoms last?			
	d.	Was Heparin administration d	iscontinued as a result of your read	ction?		
	e.	Was the Heparin dose reduce (but not discontinued)?	ed (but not discontinued) or was	the infusion rate of the Heparin reduced		
4.		scribe in detail any treatment y s above, if any, including any ho		emptoms described in response to Question		

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
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?
	If yes, please attach copies of all such readings or measurements (including computer readouts o 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?
	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:
	The date and mainter in which art such conversation(s) of 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 of 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?
	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:
	201
	b. The date and manner in which all such conversation(s) or communication(s) occurred:

	a <del>l</del>	PART VIII.	DAMAGES
Are	e you claiming any bodily	injury as a result of using H	Ieparin?Yes: □ No:
If y	ves, please describe in deta	nil the physical injury(ies) yo	ou claim were caused by your use of Heparin:
Wł	nen did this/these injury(ie	s) occur?	
Wł	nat were you doing immed	liately before and during the	time the injury(ies) occurred?
		is/these injury(ies)?owing information for each	injury requiring hospitalization:
	Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)
		g-	SIDP I
 Are	e you claiming a death wa	s caused by contaminated H	[eparin?
If y	ves, please answer the foll	owing questions. If no, plea	ise proceed to Section F.
1.	Was the patient hospitali	zed at the time of death?	Yes: □ No:
2.			ssion during which he or she allegedly
3.	How long after the patien	nt allegedly received contam	ninated Heparin did the death occur?
4.	Was the patient receiving	g Heparin at the time of deat	h?
	If no, how long after the		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 recor	ded in the patient's death certificate?
7.		and the state of t	r health care professional or provider who ever saw eath was caused by the administration of contaminate

		If yes, please state and describe.  a. The date and manner in which a	all such conversation(s) or co	ommunication(s) occurre	ed:
		b. The names of all doctors or heal	Ith care professionals or pro	viders with whom you ha	ad these discussions:
		c. What was said or communicate	d to you in each communic	ation by each doctor or h	nealth care professional
		or provider named above:			CHAR
F.		you claim or expect to claim that your use of Heparin?			capacity as a result of
		Please complete the following inform		employment for the past	ten (10) years.
		Employer(s)	Address	Type of Business/ Position	Dates of Employment
		Do you claim you have lost time frouse of Heparin?			Yes: □ No: □
		Time:	Income: \$	nd the total amount of the	_
	3.	State your earned income for each o	of the last five years.		
			Income		
			\$ \$		
G.	Hav	ve you paid or incurred any out-of- claim was caused by your use of He			
	If y	es, describe the out-of-pocket expens	-	-	
		a. Type of expense:			
		b. Amount incurred: \$	10 N N N		

# PART IX. FACT WITNESSES

Name:	
Subject(s) of information:	
Name:	
Address:	
	2037
Subject(s) of information:	
Name:	
Address:	
Relationship to you:	
Subject(s) of information:	
Name:	
Address:	
Relationship to you:	
Subject(s) of information:	
Relationship to you:  Subject(s) of information:	

#### 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.

### 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.

	-10	
Signature	M. SUB.	Date
Signature  PROFILECTIFIED TOOCULARITY TO THE PROFILECTIFIED TO THE		
or Heritin pole		
PRO.		

## **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.	A. For your current family and/or primary care physician provide the following information:					
	Name:		OB.			
	City, State, Zip Code:					
	Approx. Dates of Care:		- CO			
B. Provide the following information for each primary care physician, family or general prainternal medicine physician who has seen or treated you over the ten (10) years before your He the present (excluding the current family and/or primary health care physician listed in A above):						
	Name	Address	Approximate date(s) of treatment			
		TEC,				
		ello.				
		ME				
C.	Provide the following information fo seen or treated you:	r each nephrologist and other kidney	or dialysis specialist who has ever			
	Name	Address	Approximate date(s) of treatment			
	TAR.	11001000	0. 1.041.1101.1			
	10 D					
D.	Provide the following information for	r each endocrinologist who has ever so	een or treated you:			
4	Name	Address	Approximate date(s) of treatment			

				0
				aplin
Provide the following info	ormation for each cardiolog	ist and heart or o	hest surg	rean who has ever seen or
treated you:	rination for each cardiolog	ist and neart or c	nest sur	con valo has ever seen of
Name	Ad	dress	6	Approximate date(s) of treatment
			PP	
		173	) ′	
		C)		
		TB.		
r. 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 d of treatmer		Reason(s) for treatment
	~ OO			
	CITY'			
	Ar			
. Identify each hospital, cl emergency room visit) for t	linic and healthcare facilithe five (5) years before you			
Name	Address	Treatment da	te(s)	Reason(s) for treatment
RE				
RO				
			_	

E. Provide the following information for each allergist, immunologist, and ear, nose and throat (ENT)

Address

Approximate date(s) of treatment

specialist who has ever seen or treated you:

Name

years before yo	our Heparin injury t	to the present:		
Name	of Pharmacy	Addres	ss of Pharmacy	Approximate Dates/Years You Used Pharmacy
	•			į
				OEF.
				(P)
20 20 20 20 20 20 20 20 20 20 20 20 20 2				
Heparin, list ea	ach psychiatrist, p	psychologist and/or		onal injuries as a result of takin om you have received treatment ollowing information:
Name	e	Address	Approximate date(s) of treatment	Psychiatric, psychological, o emotional condition(s)
			,OP	(*)
			By	
	lowing information the last ten (10) y		rganization that has provi	ded you with medical or healt
Insurance C	AMM A MV	Address	Approximate date(s) of coverage	Policy type and number
msurance	отрану	Address	of coverage	roncy type and number
		200		
		()		
	(E)	7		
				re (5) years before your Hepari kely to have records concernin
Name:	0			
Street Address:				
City, State, Zip	Code:			
A 12-01	bmitted a claim for nave records concer	_	ation, state the name and	d address of the office which
Name:				
Street Address:				

I. Identify each pharmacy, drugstore and other facility that has dispensed medication to you for the five (5)

# **EXHIBIT B**

# <u>LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION</u> (Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: Patient Name:	DOB:	SSN:
I, , her	reby authorize you to release	and furnish to: MRC Medical Research
Consultants copies of the following infor	(A)	(E)
		room treatment, all clinical charts, reports,
records received by other physicians. S status.	Said medical records shall include	stories, office and handwritten notes, and de all information regarding AIDS and HIV CT Scan, MRI, echocardiogram and cardiac
catheterization reports.	, <i>B</i> ,, <b>,</b> <i>B</i> ,, <i>B</i> ,,	
recordings, photographs, bone scans or in immunohistochemistry specimens or sl	mages or recordings of any kind	MRI films, MRA films, echocardiographic l, pathology/cytology/histology/autopsy/ ideos/CDs/films/reels, and echocardiogram
videos.  * All pharmacy/prescription records inc  * All billing records including all stater  * All ampleyment records wege records	ments, itemized bills, and insura	nee records.
* All employment records, wage record		-c service deserve resident account account to the same
defendants. You are not authorize care, treatment, diagnosis, progrematter bearing on his or her medic permitting such discussion. Subjective discussing my medical history, ca	eed to discuss any aspect of the osis, information revealed by cal or physical condition, unleaded to all applicable legal object to all applicable legal objects, treatment, diagnosis, programment, diagnosis,	d by, or on behalf of, attorneys for the above-named person's medical history, or in the medical records, or any other ss you receive an additional authorization ections, this restriction does not apply to gnosis, information revealed by or in the physical condition at a deposition or trial.
disease, acquired immunodeficiency	y syndrome (AIDS), or human i	information relating to sexually transmitted mmunodeficiency virus (HIV). It may also treatment for alcohol and drug abuse.
authorization I must do so in writing department. I understand the revoca to this authorization. I understand	g and present my written revocation will not apply to information the revocation will not apply to contest a claim under my	ny time. I understand that if I revoke this ation to the health information management on that has already been released in response to my insurance company when the law y policy. Unless otherwise revoked, this
authorization. I need not sign this information to be used or disclos information carries with it the potential	form in order to assure treatme ed as provided in CFR 164.5 ential for an unauthorized re-d rules. If I have questions about	tion is voluntary. I can refuse to sign this nt. I understand I may inspect or copy the 24. I understand that any disclosure of lisclosure and the information may not be t disclosure of my health information, I can
<ol><li>A notarized signature is not required original.</li></ol>	d. CFR 164.508. A copy of th	is authorization may be used in place of an
Print Name (plaintiff/rep	presentative):	

Date: \_

Signature:

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

	) MDL Docket No. 1953
IN RE: HEPARIN PRODUCTS LIABILITY LITIGATION	) Chief Judge James G. Carr
LIABILITY LITIGATION	) Chief Judge James G. Carr
THIS DOCUMENT RELATES TO	
MDL DOCKET NO. 1953	
PLAINTIFF:NAME(S)	
1.12.12.(8)	
HEPARIN PLAINTIFF FACT	SHEET: OTHER PROCEDURE
	eparin during a MEDICAL PROCEDURE <u>UNRELATED</u> DURE, please <u>COMPLETE THIS FACT SHEET</u> .
	Y '
	ust provide information that is true and accurate to the best of requested, please provide as much information as you can.
	u have any questions regarding the completion of this Fact
Sheet. If you are completing the Fact Sheet as the a	uthorized legal representative on behalf of the person who
received contaminated Heparin, please answer the questi	
Please attach as many additional sheets of paper as neces	ssary to fully complete each question on this Fact Sheet.
PART I. CAS	E INFORMATION
<del>,</del>	E INFORMATION
A. Please state the following for the civil action which y	
A. Please state the following for the civil action which y  1. Case Caption:	
A. Please state the following for the civil action which y	
<ol> <li>A. Please state the following for the civil action which y</li> <li>Case Caption:         <ol> <li>MDL Civil Action No.:</li> <li>[Please Note: If you are completing this Fact</li> </ol> </li> </ol>	Sheet in a representative capacity, please respond to the
<ul> <li>A. Please state the following for the civil action which y</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Fact remaining questions with respect to the personnel.</li> </ul>	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term
<ul> <li>A. Please state the following for the civil action which y</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Fact remaining questions with respect to the personnel.</li> </ul>	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time
A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Fact remaining questions with respect to the persure "You" refer to the person who used Heparin.	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time
<ul> <li>A. Please state the following for the civil action which y</li> <li>1. Case Caption: <ol> <li>MDL Civil Action No.:</li> </ol> </li> <li>[Please Note: If you are completing this Fact remaining questions with respect to the pers "You" refer to the person who used Heparin. immediately prior to his or her death unless a</li> <li>B. Claim Information:</li> </ul>	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]
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<ol> <li>A. Please state the following for the civil action which y         <ol> <li>Case Caption:</li> <li>MDL Civil Action No.:</li> <li>[Please Note: If you are completing this Fact remaining questions with respect to the pers "You" refer to the person who used Heparin. immediately prior to his or her death unless a</li> <li>B. Claim Information:</li></ol></li></ol>	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]
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A. Please state the following for the civil action which y  1. Case Caption:  2. MDL Civil Action No.:  [Please Note: If you are completing this Fact remaining questions with respect to the pers "You" refer to the person who used Heparin. immediately prior to his or her death unless a  B. Claim Information:  1. Name, address, telephone number, fax number are this lawsuit:  Name:  Firm:	Sheet in a representative capacity, please respond to the son who used Heparin. Those questions using the term If the individual is deceased, please respond as of the time different time period is specified.]  Indeed, the principal attorney representing you in
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THE REST OF THIS FACT SHEET REQUIRES INFORMATION ABOUT THE PERSON WHO USED HEPARIN.

E-mail Address:

## PART II. PERSONAL INFORMATION

A. Identifying Information:

	1.				9.7	
		Last Name	Firs	t Name		Middle Name
	2.	Maiden or other names used or by wh	ich you have bee	n known:		
	3.	Current Address:				
		Street Address:				A CO
		City, State, and Zip Code:				.00
	4.	Current or Last Employer:				R
		Name:				Ø.0'
		Street Address:				MY
		City, State, and Zip Code:				6,7,
		Dates of Employment:				The same of the sa
		Occupation:				6,
	5.	Social Security Number:			2/3	
	6.	Date of Birth: Month:	Day:	Year:	40,	
	7.	Sex: Male: □ Female: □				
D		ve you ever filed a worker's compens	ation alaim: agai	al acqueity Ale	Ability alaimy	or a lawayit ather than the
В.	pre	esent suit, relating to any bodily injury?	·	ar security dis	sability Claim,	Yes: No:
		yes, for each such claim please state:		50) N		
	870	Type of claim filed (e.g., worker's con	mpensation, socia	al security, etc	.):	
		Date claim was filed:	- · ·	Contract of the Contract of th	· -	
		Where claim was filed (e.g., court, de	10. 9	M		
		Claim/docket number, if applicable: _	60.	5500 449		
		Nature of claim/disability:	0			
		Period of disability:	k Y			
			ay.	T MEDICAI	CONDITION	.T
	_	PART III. PLAIN				
A.	Is p	plaintiff deceased? Yes:   No:   If	yes, please proce	ed to Part IV.	If no, please	answer question III. B-C.
В.	Hei	ight: Current W	/eight:			
C.	Do	you currently suffer from any of the fo	ollowing 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		: □ No: □		
	8.	Connective tissue or autoimmune dise				
		(including lupus, rheumatoid arthritis, scleroderma, and collagen vascular di		· □ No: □		
	9.	Congestive heart failure (CHF)				
		Coronary artery disease (CAD)				

11.	Anemia	Yes: [	□ No: □	
12.	Arrhythmia	Yes: [	□ No: □	
	Bleeding or clotting disorders (includ hemophilia or Heparin-induced throm (HIT))	nbocytopenia	∃ No: □	
	Cancer			
	Vasculitis			
			」 NO. □	
	Lung disease (including but not limite and emphysema)		I No∙ □	
	Other*			2017
	* Please identify any other disease(s)			CIF.
	require(s) in-patient or out-patient me continuing or periodic episodes of inc	edical care and/or re		
r eacl	n disease or condition identified above		_	THC I
	Injury/Illness/Disability	Approximate Date of Onset	Approximate Date of Diagnosis	Name and Address of First Diagnosing Physician
			02	
			165	
	<u>PART IV. PI</u>	LAINTIFF MEDIC	CAL BACKGROUND	<u>)</u>
	oking history: Never smoked cigare		er of eigarettes: 🗆 C	urrent smoker of cigarettes:
If pa	ast or current smoker: packs pe	er day for ye	ars.	
Med	lications			
	List all medications (including presc you were taking regularly or periodi claim you were administered con	cally WITHIN TH ntaminated Hepar	E SIX MONTHS BEF	ORE the date(s) on which you
	(antihypertensive) medications and an	nudioucs.		
	Name of Medication	,	Dosage	Frequency (e.g., 1 x day)
	40/2			
	-00			
	40,00			
ĵ	List all medications (including presc you took WITHIN 24 HOURS BE contaminated Heparin, including b antibiotics.	FORE or AFTER	the time(s) that you	claim you were administered
	Name of Medication			F
			Dosage	Frequency (e.g., 1 x day)
			Dosage	Frequency (e.g., 1 x day)
			Dosage	Frequency (e.g., 1 x day)
			Dosage	Frequency (e.g., 1 x day)

C.				ou ever experience a of your claims in this	-	following I	URING	THE FIVE YE	ARS
	1.	Shortness of brea	th not associated wi	th vigorous					
		exercise		Yes: □	No: □				
	2.	Chest tightness		Yes: 🗆	No: □				
	3.	Persistent or recu	rrent pain in chest	Yes: □	No: □				
	4.	Low blood pressu	ıre	Yes: □	No: □				
	5.	_	at, including heart por bradycardia	oalpitations, Yes:	No: □				(B)
	6.	Audible wheezing	g	Yes: □	No: □			0	$\mathcal{Y}_{\lambda}$
	7.	_	outh or throat or di	fficulty Yes:	No: □			CITYE OR	
	8.		elling of the lips, to					My	
				Yes: □	No: □			C. J.	
	9.	Swelling in the ha	ands	Yes: □	No: □		- 4		
	10.	Numbness or ting	gling	Yes: □	No: □		00,		
	11.	Generalized or lo	calized sensations o	of burning or		<	3		
		warmth		Yes: □	No: □	00	>		
	12.	Dizziness or light	theadedness	Yes: □	No: □				
	13.	Fainting		Yes: □	No: □	C.			
	14.	Chronic nausea, v	vomiting, or diarrhe	a Yes: 🗆	No: □				
	15.	Chronic abdomin	al pain	Yes: 🗆	No: □○	3			
	16.	Hives or urticaria		Yes: 🗆	No; □				
	17.	Seizures		Yes: 🗓	No: □				
	18.	Skin rashes		Yes: 🛛	No: □				
	19.	Flushing of face	or other parts of the	bodyYes: □	No: □				
	20.	Diaphoresis (exce	essive sweating)	Yes: 🗆	No: □				
	21.	Blurred vision		Yes: □	No: □				
D.	If y	ou responded yes	to any of the above,	state the following:					
			Approximate	Circumstances Under		Duration		Name and Addre	
	$\vdash$	Condition(s)	Date of Onset	Condition(s) Occur	reu	Condition	n(s)	Physician (if ar	iy)
			200						
			00						
			Cir						
г	т.				1		1.1 0.27 4.7002		pulses diseases
E.			nowledge, have you had any of the follo	ever been told by a	doctor or	any other he	aith care	professional that	you
	1.			Yes:	No: □				
		T Y	_	Yes:	No: □				
	2.								
	3.		-	Yes:					
	4. =		_	elet count Yes:	No: □				
	5.			Yes: □	No: □				
	6.			Yes: □	No: □				
	7.			Yes: □	No: □				
	8.	Congestive heart	Tailure (CHF)	Yes: 🗆	No: ⊔				

9.	Myocardial infarction	n (heart attack)	Yes: □	No: □	
10	. Coronary artery disea	ase (CAD)	Yes: □	No: □	
11	. Vascular artery disea	se	Yes: □	No: □	
12	. Valvular heart diseas	e	Yes: 🗆	No: □	
13	. Stroke or transient is	chemic attack	Yes: 🗆	No: □	
14	. Anemia, bleeding, or	hemorrhagic disorder	Yes: 🗆	No: □	
15	. Blood clotting diseas	e or disorder	Yes: □	No: □	
16	. Seizures		Yes: 🗆	No: □	
17	Liver disease (includ hepatitis)	ing but not limited to	Yes: □	No: □	RDY
18	. Diabetes		Yes: 🗆	No: □	~
19	. Adverse reaction to in	mmunization	Yes: □	No: □	
20	. Hypersensitive or all	ergic reaction to any drug.	Yes: □	No: □	
21	. Hypersensitive or adv	verse reaction to Heparin	Yes: □	No: □	
22	. Eczema		Yes: 🗆	No: □	C. J.
23	arthritis, sarcoidosis,	autoimmune disease nited to lupus, rheumatoid vasculitis, scleroderma, an ease)		No: □	TO PROTECTIVE ORDER
24		ng of the lips, tongue, or		6	y .
	•			A 30 3	
				No: 🛛	
26		ing but not limited to COP		Na. D	
27			7	The second control of	
		L	~ 19.7		
		enous thrombosisve sweating)			
	*	ny of the above, please cor			
	Condition(s)	Appro	ximate Date	of Onset	Name and Address of Physician
		~			
		<b>Y</b>			
		nated or treated by an allerge following for each allergis			Yes:  No:  s evaluated or treated you:
	Nama	Address		ximate Date(s) of ation/Treatment	Reason(s) for Evaluation/Treatment
	Name	Audiess	Evalu	andiv i i calillelli	Acason(s) for Evaluation Heatment
	*				

H.	To the best of your knowledge,	, have you ever experi	enced an aller	rgic reaction to any	of the following:	
	1. Food		Yes: □ No	: 🗆		
	2. Drugs or medications (inclantibiotics, anesthesia, and	4. C.		: <b>□</b>		
	3. Seasonal irritants (e.g., pol	• ′				
	4. Insects					
	5. Animals (including animal					
	6. Mold				83	
	7. Dyes		Yes: □ No	: <b>□</b>	20K	
	8. Latex		Yes: □ No	: 🗆	OF	
	9. Other		Yes: □ No	: □	18	
I.	If you responded yes to any of	the above, please com	plete the foll	owing:	all la	
	Substance	Nature of the Reaction	n Ap	proximate Date(s)	Name and Address of Physician (if any)	
					90,	
				$O_{\lambda}$		
J.	To the best of your knowledge contaminated Heparin?	e, did you ever receiv	ve Heparin pr	ior to the date on w	which you claim you received Yes:   No:	
K.	Before your claimed exposu administration of Heparin?					
	If you responded yes, please co	No. 200 (200 (200 (200 (200 (200 (200 (200				
	Reaction(s)	Approximate Reaction		Duration of Reaction(s)	Name and Address of Physician	
		a C	, ·			
		N. D.				
L.	Before your claimed exposur transfusion of blood or any blo	od product (e.g., plasi	ma)?			
	If you responded yes, please co	implete the following	:			
	Reaction(s)  Approximate Date(s 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	Hamital ar O	ther Surgical Facility	Name and Address of Surgeon	
	1 y pe of Surgery	Date of Surgery	1105pital 01 O	mei Suigicai Pacifity	Traine and Address of Sui geon	

## PART V. FAMILY MEDICAL BACKGROUND

A.	Has any parent, sibling or offspring be	en diagnosed with, experienced or suff	ered from the following:				
	1. Adverse reactions to anesthesia	Yes: □ No: □ Don't l	know: □				
	2. Adverse reactions to immunization	nYes: 🗆 No: 🗆 Don't l	know: □				
	3. Hypersensitivity/adverse reaction	to Heparin Yes: 🗆 No: 🗆 Don't l	know: □				
	4. Adverse reactions to dialysis	Yes: □ No: □ Don't l	know: □				
В.	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				
			180				
C.	Has any parent, sibling or offspring has with epinephrine?	ad a history of severe allergic reactions					
	If yes, please provide the following:		SE				
	Relationship	Current Age (or Age at Death)	Type of Reaction				
			,				
	PART	Γ VI. PRODUCT IDENTIFICATION	N_				
A.	Do you contend that you have suffered an injury as a result of the administration of contaminated Heparin?						
	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:						
В.	If you contend you received contaminancessary to provide the information f		n, please attach additional sheets as				

## PART VII. OTHER PROCEDURE AND EXPOSURE TO CONTAMINATED HEPARIN

B. Identify the type of surgery or procedure you were undergoing:								
Σ.	Provide the date of the surgery or procedure, the name of the physician performing the surgery or proced the name of the facility where the procedure was performed.							
		Date of Procedure	Treating Physician	Facility				
				TE ST				
O.	We	re you hospitalized prior to the time		□ No: □				
		If yes, for how long prior to the su	rgery or procedure?					
Ξ.	Cla	imed Exposure and Response to Co	ontaminated Heparin.	PIE				
	1.	Date and approximate time that yo	our surgery or procedure began.					
	2.		ou believe you experienced symp	toms allegedly related to contaminated				
	3.	Describe in detail the injuries and symptoms you believe you suffered as a result of administration of contaminated Heparin.						
		<u>, , , , , , , , , , , , , , , , , , , </u>						
			0					
		a. How was Heparin administere	d to you?Intraver	nously: Subcutaneously: Don't know:				
		b. How soon after administration	on of the Heparin did you su	ffer 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?						
		d. Was Heparin administration di	is contained as a resolution your re	<del></del>				
		e. Was the Heparin dose reduce		as the infusion rate of the Heparin reduced				

Э.	, ,	ipt of contaminated Heparin?							
	b. antihista	ne sulfate							
6.		ve any blood pressure readings or measurements taken at any time during the 24 hours BEFORE the administration of allegedly contaminated Heparin?							
		se attach copies of all such readings or measurements (including computer readouts or summaries your possession or the possession of your attorneys or other agents or representatives.							
7.	that your	octor or health care professional or provider who has ever seen or treated you told you symptoms or injuries were caused by the administration of contaminated Yes:   Yes:  No:							
	If yes, pleas	e state and describe to the best of your recollection:							
	a. The nan	nes of all doctors or health care professionals or providers who told you this:							
	7								
	b. The date	The date and manner in which all such conversation(s) or communication(s) occurred:							
	_	- COP							
		What was said or communicated to you in each conversation or communication by each doctor or health care professional or provider named above:							
	Ü-								
8.	other discus	to any discussions or communications identified in Question 7 above, have you had any ssions with any doctor or health care professional or provider who has seen or treated you her your symptoms or injuries were caused or not caused by the administration of contaminated Yes:   Yes:  No:							
	If yes, pleas	e state and describe to the best of your recollection:							
	a. The nan	nes of all doctors or health care professionals or providers with whom you had these discussions:							
	OP								
	b. The date	e and manner in which all such conversation(s) or communication(s) occurred:							

		PART VIII.	DAMAGES
Are	you claiming any bodily	injury as a result of using H	Ieparin?Yes: 🗆 No: 🗆
If y	es, please describe in det	ail the physical injury(ies) y	ou claim were caused by your use of Heparin:
Wł	nen did this/these injury(io	es) occur?	JE OF
Wł	nat were you doing immed	diately before and during the	e time the injury(ies) occurred?
We	ere you hospitalized for th	is/these injury(ies)?	Yes:  No: [
If y	- 1247 - 71 		injury requiring hospitalization:
	Approximate Date(s) of Hospital Admission	Approximate Date(s) of Discharge	Hospital Name(s) and Address(es)
			culp.
			13
Are	e you claiming a death wa	ns caused by contaminated H	[eparin?
If y	es, please answer the foll	lowing questions. If no, plea	ase proceed to Section F.
1.	Was the patient hospital	ized at the time of death?	Yes: □ No: □
2.	_		ssion during which he or she allegedly Yes: \( \simeg \) No: \( \simeg \)
3.	How long after the patie	nt allegedly received contan	ninated Heparin did the death occur?
4.	Was the patient receiving	g Heparin at the time of dea	th?
	( - 7		Heparin did the death occur?
5.	What was the cause(s) o	f patient's death as recorded	in the patient's medical chart?
	What was the cause(s) of the patient's death as recorded in the patient's death certificate?		

		If yes, please state and describe.  a. The date and manner in which a	all such conversation(s) or co	ommunication(s) occurre	ed:
		b. The names of all doctors or heal	Ith care professionals or pro	viders with whom you ha	ad these discussions:
		c. What was said or communicate	d to you in each communic	ation by each doctor or h	nealth care professional
		or provider named above:			CHAR
F.		you claim or expect to claim that your use of Heparin?			capacity as a result of
		Please complete the following inform		employment for the past	ten (10) years.
		Employer(s)	Address	Type of Business/ Position	Dates of Employment
		Do you claim you have lost time frouse of Heparin?			Yes: □ No: □
		Time:	Income: \$	nd the total amount of the	_
	3.	State your earned income for each o	of the last five years.		
			Income		
			\$ \$		
G.	Hav	ve you paid or incurred any out-of- claim was caused by your use of He			
	If y	es, describe the out-of-pocket expens	-	-	
		a. Type of expense:			
		b. Amount incurred: \$	10 N N N		

## PART IX. FACT WITNESSES

Name:	
Subject(s) of information:	
Name:	
Address:	
	2037
Subject(s) of information:	
Name:	
Address:	
Relationship to you:	
Subject(s) of information:	
Name:	
Address:	
Relationship to you:	
Subject(s) of information:	
Relationship to you:  Subject(s) of information:	

#### 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.

### 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.

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Signature		Date
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Signature  PROFILECTER PROFILE OF THE PROFILE OF TH		
N/A		
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Y		

## **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 primar	g information:				
	Name:		OB.			
	City, State, Zip Code:					
	Approx. Dates of Care:		- CO			
В.	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			
		TEC,				
		ello.				
		ME				
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			
	TAR.	11001000	0. 1.041.1101.1			
	10 D					
D.	Provide the following information for	r each endocrinologist who has ever so	een or treated you:			
4	Name	Address	Approximate date(s) of treatment			

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D :1 4 CH : :	· · ·			Temporal acustosam	O,
treated you:	Iormation I	or each cardiolog	gist and heart or c	chest surg	geon who has ever seen or
Name		Ad	dress	0	Approximate date(s) of treatment
				QR2	
			173	) ′	
			C)		
			TB1		
For any other physician or psychological treatmer present (who has not already	nt) who has	treated or seen you	a over the five (5) ye	ears befor	e your Heparin injury to the
Name		Address	Approximate d of treatmer		Reason(s) for treatment
	^	00			
	W.	,			
, and	2 July				
I. Identify each hospital, emergency room visit) for					
Name		Address	Treatment da	te(s)	Reason(s) for treatment
THE STATE OF THE S					
oRO.					
					_

E. Provide the following information for each allergist, immunologist, and ear, nose and throat (ENT)

Address

Approximate date(s) of treatment

specialist who has ever seen or treated you:

Name

years before yo	ur Heparin injury	to the present:		
Name	of Pharmacy	Addres	ss of Pharmacy	Approximate Dates/Years You Used Pharmacy
	•		•	•
				OEF.
				(P)
20 20 20 20 20 20 20				
Heparin, list ea	ich psychiatrist, j	psychologist and/or		nal injuries as a result of takin om you have received treatment ollowing information:
Name	•	Address	Approximate date(s) of treatment	Psychiatric, psychological, o emotional condition(s)
			OP	(-)
			By	
	lowing information the last ten (10) y	1.7	rganization that has provi	ded you with medical or healt
Insurance C		Address	Approximate date(s) of coverage	Policy type and number
msurance	опрану	Address	of coverage	roncy type and number
		200		
		C)		
	(E)			
				e (5) years before your Hepari kely to have records concernin
Name:	0			
Street Address:				
City, State, Zip	Code:			
4 -	bmitted a claim for	-	ation, state the name and	d address of the office which
Name:				
Street Address:				

I. Identify each pharmacy, drugstore and other facility that has dispensed medication to you for the five (5)

# **EXHIBIT B**

# <u>LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION</u> (Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: Patient Name:	DOB:	SSN:
I, , her	reby authorize you to release	and furnish to: MRC Medical Research
Consultants copies of the following info	70	OE)
		room treatment, all clinical charts, reports,
records received by other physicians. Status.	Said medical records shall include	stories, office and handwritten notes, and le all information regarding AIDS and HIV CT Scan, MRI, echocardiogram and cardiac
catheterization reports.	,	
recordings, photographs, bone scans or i immunohistochemistry specimens or si	images or recordings of any kind	MRI films, MRA films, echocardiographic l, pathology/cytology/histology/autopsy/ ideos/CDs/films/reels, and echocardiogram
videos.  * All pharmacy/prescription records inc  * All billing records including all states  * All ampleyment records.	ments, itemized bills, and insura	nee records.
* All employment records, wage record		- Caracinocard remark andrews and annual masks in consider
defendants. You are not authorize care, treatment, diagnosis, progn matter bearing on his or her medi permitting such discussion. Subjective discussing my medical history, care	zed to discuss any aspect of the losis, information revealed by ical or physical condition, unlessed to all applicable legal objects, treatment, diagnosis, programs, treatment, diagnosis, programs.	d by, or on behalf of, attorneys for the e above-named person's medical history, or in the medical records, or any others you receive an additional authorization ections, this restriction does not apply to gnosis, information revealed by or in the physical condition at a deposition or trial.
disease, acquired immunodeficiency	y syndrome (AIDS), or human is	information relating to sexually transmitted mmunodeficiency virus (HIV). It may also treatment for alcohol and drug abuse.
authorization I must do so in writing department. I understand the revocato this authorization. I understand	ng and present my written revocation will not apply to information the revocation will not apply to contest a claim under my	ny time. I understand that if I revoke this ation to the health information management on that has already been released in response to my insurance company when the law y policy. Unless otherwise revoked, this
authorization. I need not sign this information to be used or disclos information carries with it the pot	form in order to assure treatments as provided in CFR 164.5 tential for an unauthorized reductions about	tion is voluntary. I can refuse to sign this nt. I understand I may inspect or copy the 24. I understand that any disclosure of isclosure and the information may not be t disclosure of my health information, I can
<ol><li>A notarized signature is not require original.</li></ol>	d. CFR 164.508. A copy of th	is authorization may be used in place of an
Print Name (plaintiff/re	presentative):	

Date: \_

Signature: