UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: ORAL SODIUM PHOSPHATE SOLUTION-BASED ("OSPS") PRODUCTS LIABILITY ACTION	:	**Case No. 1:09-SP-80000 (MDL Docket No. 2066)**
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This Document Relates to	:	**JUDGE ALDRICH**
ALL ACTIONS	:	
	:	**"PFS" ORDER**

In section VIII.H.2 of the Court's Case Management Order ("CMO"), the Court noted that, in order to "provid[e] the parties with sufficient claims-specific information to enable them to proceed with meaningful settlement negotiations, the parties have agreed to the preliminary use of a short form plaintiff fact sheet ('short form PFS')."[1] The CMO further noted the Court would discuss the short form PFS in a "PFS Order." This is the PFS Order.

The short form PFS that plaintiffs will use is attached as an exhibit to this Order. The Court directs plaintiffs' liaison counsel to forward this PFS Order and electronic copies of the short form PFS to all attorneys who represent *OSPS* claimants.[2] To the extent possible, this distribution should include not only attorneys who have filed *OSPS* claims on behalf of plaintiffs in this MDL court,

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[1] *See* master docket entry no. 48 at 15.

[2] The Court has seen various electronic versions of the short form PFS, including a Word document and a "fillable PDF document." Liaison Counsel should forward all those electronic version(s), to make it easiest for counsel to comply. Further, Liaison Counsel should forward a copy of the agreed-upon HIPAA-complaint medical records authorization form, which is also attached as an exhibit to this Order.

but also to attorneys who have: (1) filed *OSPS* claims on behalf of plaintiffs in state courts; and (2) suggested they represent clients with OSPS claims, but have not yet formally filed a complaint in any court.

As stated earlier in the CMO, the Court **ORDERS** as follows: "Each named plaintiff in any action currently pending in or subsequently made a part of MDL 2066 who has not previously answered interrogatories propounded by Fleet and produced medical authorizations to Fleet shall complete a short form PFS within thirty (30) days of the date of this 'PFS Order,' or within thirty (30) days of becoming part of this MDL proceeding (either by direct filing in or transfer to the MDL), and provide a copy of this short form PFS to Fleet and to the PEC."[3]

In addition, the Court also **REQUESTS and DIRECTS** as follows: First, plaintiffs' counsel with cases pending in this MDL shall strive to provide the required short form PFS for each case *as soon as possible*; although the deadline is 30 days from the date of this Order, the Court directs counsel to try and beat this deadline handily, and to produce short form PFSs on a rolling basis.

Second, the Court requests that *all* attorneys who represent *OSPS* claimants voluntarily provide a short form PFS for each such claimant, *even if the claimant is not an MDL plaintiff*. The purpose of collecting these short form PFSs is so that the parties and the Court may assess the entire universe of *OSPS* claimants, with the goal of achieving a global resolution of all such claims, regardless of where (or whether yet) filed. The parties and the Court are making substantial progress in reaching this goal. The voluntary provision of a short form PFS by counsel, even though their

[3] *Id.*

claims are not pending in this MDL, will be of great assistance in this effort.

IT IS SO ORDERED.

/s/ *Ann Aldrich*
ANN ALDRICH
UNITED STATES DISTRICT JUDGE

Dated: November 24, 2009

Oral Sodium Phosphate Litigation
Plaintiff's Preliminary Fact Sheet

PLAINTIFF CONTACT INFORMATION

Last Name:_____ First Name:_____
Address:_____
Telephone:_____
Spouse's Name:_____

PLAINTIFF'S ATTORNEY CONTACT INFORMATION

Name:_____
Law Firm:_____
Address:_____
Telephone:_____ Email:_____

PLAINTIFF'S PERSONAL AND HEALTH INFORMATION

Date of Birth (mm/dd/yyyy): _____
Gender: Male Female
Are you African-American[1]?: Yes No

Did you use a Fleet Phospho-Soda product? Yes No
If your answer is "Yes," which Fleet Product did you use? (check all that apply)

- ❑ Fleet Phospho-Soda (1.5 ounce/45 mL)
- ❑ Fleet Phospho-Soda (3.0 ounce/90 mL)
- ❑ Fleet Accu-Prep
- ❑ Fleet Phospho-Soda EZ-Prep
- ❑ Other: _____

On what date(s) did you use the Fleet Product? (mm/dd/yyyy): _____ _____
_____ _____ _____ _____ _____

Did you use the Fleet Product in connection with a medical procedure? Yes No
If your answer is "Yes," state:

1. What medical procedure? _____
2. What was the date of the medical procedure? (mm/dd/yyyy):_____
3. Name and address of the doctor who performed the medical procedure?_____
   _____
   _____

[1] Plaintiff's race is requested in order to calculate estimated normal kidney function, which depends on race, gender, and age, among other factors. Kidney function is measured by glomerular filtration rate ("GFR"), using the Modification of Diet in Renal Disease ("MDRD") Study equation; this equation uses different factors depending on the patient's race. *See* www.nkdep.nih.gov/professionals/gfr_calculators/orig_con.htm .

DETAILS OF FLEET PRODUCT USE

Please answer the following questions regarding the manner in which you used the Fleet Product.

A. Number of doses: _____
B. Amount of Fleet Product in each dose:_____
   (Please state in ounces (oz), milligrams (mL), or some other estimated volume, such as teaspoons or tablespoons).
C. Amount of time (in hours) between doses: _____
D. Other laxative products used at the same time: _____

List any medications you were taking during the period starting two weeks before you used the Fleet Product through the time you were diagnosed with the injuries you are claiming:_____
_____
_____
_____
_____
_____
_____
_____

DETAILS OF KIDNEY FUNCTION

Do you know what your serum creatinine level was the last time it was measured before using a Fleet Product? Yes No
If you answered "Yes," state the measurement: _____
The approximate date of the measurement (mm/dd/yyyy):_____

Do you know what your serum creatinine level was the first time it was measured after using a Fleet Product?
Yes No
If you answered "Yes," state the measurement: _____
The approximate date of the measurement (mm/dd/yyyy): _____

What is your most recent serum creatinine level? _____
What is your most recent eGFR (estimated glomerular filtration rate)? _____

Have you ever been diagnosed with kidney disease? Yes No
If you answered "Yes," state the date you were first diagnosed (mm/dd/yyyy): _____
Name and address of the doctor making that diagnosis: _____
_____
_____

Have you had a kidney biopsy? Yes No
If you answered "Yes," state the date of the biopsy (mm/dd/yyyy): _____

Have you ever required dialysis? Yes No
If you answered "Yes," state:

1. the type of dialysis you had:_____
2. the period you underwent dialysis (mm/dd/yyyy):_____to _____
3. the frequency of the treatments (e.g., daily, 2x/week; 3x/week): _____

Have you been placed on a kidney transplant list? Yes No
If you answered "Yes," state the date you were first put on such list (mm/dd/yyyy): _____

Have you had a kidney transplant? Yes No
If you answered "Yes," state the date of the transplant (mm/dd/yyyy): _____

Have you suffered any injury other than kidney disease that a doctor has related to your use of a Fleet Product? Yes No
If you answered "Yes," state:

1. the type of injury:_____
2. the date you were diagnosed with that injury (mm/dd/yyyy):_____
3. the name and address of the doctor who made that diagnosis: _____
   _____
   _____

RECORDS

Please provide copies of the instructions you received for taking the Fleet Product, and all medical records in your possession, including records related to:

a. your use of the Fleet Product, including but not limited to pre-procedure records, procedure records, or post-procedure records showing your use of the Fleet Product;
b. lab reports (blood work) which indicate your creatinine levels from before you used the Fleet Product;
c. lab reports (blood work) which indicate your creatinine levels from after you use the Fleet Product;
d. report of any kidney biopsy;
e. the diagnosis of acute or chronic kidney disease;
f. any treatment you received for acute or chronic kidney disease; and
g. diagnosis and any treatment you received for any injury other than kidney disease.

ATTACH A LIST OF THE NAMES AND ADDRESSES OF ALL HEALTH CARE PROVIDERS WITH WHOM THE CLAIMANT HAS TREATED FOR RENAL DISEASE, INCLUDING ALL PRIMARY CARE PHYSICIANS.

SIGNATURES

The undersigned certifies that he or she believes the above information to be true and correct based on reasonable inquiry.

_____ _____
Claimant or Claimant's Attorney Date

ALSO: please sign the attached medical records authorization.

HIPAA COMPLIANT AUTHORIZATION FOR USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Person/Entity from Whom Records are Requested: Provider Name ("Provider"): _____
Address City, State and Zip Code: _____
_____

Patient: Patient Name: _____
Address City, State and Zip Code: _____
_____
_____
Date of Birth Social Security Number

Information Authorized To Be Disclosed: I authorize the Provider to furnish copies of my entire medical record and all of my individually identifiable health information, including, without limitation:

1.	medical reports	7.	Lab test/results/reports	13.	Renal biopsy paraffin
2.	radiographic films	8.	progress notes block	14.	prescription records
3.	MRI films	9.	bowel preparation instructions	15.	medical bills
4.	CT scans	10.	sedation and procedure records	16.	written statements
5.	MRA films	11.	pathology specimens	17.	disability records
6.	X-rays	12.	Renal biopsy slides	18.	correspondence

and other documents in your possession including records from other providers to the following representative of the defendants in the litigation captioned *In re: Oral Sodium Phosphate Solution – Based Products Liability Action,* MDL No. 2066 (N.D. Ohio), in which I am a plaintiff/claimant:

Person To Whom Records Are To Be Disclosed: Name of Representative ("Requestor"): _____
Representative Capacity: _____
_____
Address City, State and Zip Code

The records requester has agreed to pay reasonable charges made by the Provider to supply copies of such records.

Purpose of Disclosure: I am requesting this disclosure to allow these records to be used in connection with the litigation in which I am a plaintiff/claimant.

Acknowledgements:

I understand that this disclosure may include information relating to treatment of drug or alcohol abuse, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), sexually transmitted diseases, sickle cell anemia treatment, tuberculosis information, and genetic testing information.

I understand that if the persons or entities to whom I am asking that the Provider disclose this information are not covered by federal privacy regulations, then this information will no longer be protected under federal privacy law and could be subject to re-disclosure.

I understand that my signing or revocation of this authorization will not affect my health care treatment or eligibility for payment under my health plan.

Term and Revocation: This authorization shall be considered as continuing in nature until a final, non-appealable judgment has been entered in the case I have brought. This authorization remains in full force and effect until such expiration, and further authorizes the Provider to release to the Requestor any additional records created or obtained by the Provider after the date hereof. I understand that I may revoke this authorization at any time by writing to the Provider at the Provider's above address, but my revocation will not apply to information that has already been released before the Provider receives notice of any revocation.

It is expressly understood by me that the Provider is authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to the Provider.

Dated: _____ _____
Signature of Patient or Personal Representative

Dated: _____ _____
Witness Signature

This authorization is not valid unless the records Requester named above has executed the following acknowledgement:

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Preliminary Fact Sheet; or, if the authorization is addressed to a third-party not listed in Plaintiff's Preliminary Fact Sheet, the attorney for the patient named in the foregoing medical authorization will be provided a copy of records from the undersigned at a reasonable cost. The attorney for the patient has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

_____