**UNITED STATES DISTRICT COURT**

**SOUTHERN DISTRICT OF OHIO**

**EASTERN DIVISION**

|  |  |
| --- | --- |
| **IN RE: DAVOL, INC./C.R. BARD, INC., POLYPROPYLENE HERNIA MESH PRODUCTS LIABILITY LITIGATION**  **This document relates to:**  **PLAINTIFF NAME** | **Case No. 2:18-md-2846**  **CHIEF JUDGE EDMUND A. SARGUS, JR.**  **Magistrate Judge Kimberly A. Jolson**    **Civil Action No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PLAINTIFF PROFILE FORM**

In completing this Plaintiff Profile Form, you must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. As used in this Plaintiff Profile Form, “Davol/C.R. Bard Hernia Mesh Device” refers to the medical device or devices identified in paragraph 7 of your Short Form Complaint.

**I. CASE INFORMATION**

**Caption:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Docket No.: \_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Attorney Contact (name, address, phone, and email):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**II. PLAINTIFF INFORMATION**

**Name of Individual Implanted with Davol/C.R. Bard Hernia Mesh Device:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Gender of Individual Implanted with Davol/C.R. Bard Hernia Mesh Device: ❑ Male ❑ Female**

**Date of birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last 4 Digits of Social Security No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Loss of Consortium Claim? ❑ Yes ❑ No**

**If yes, name of spouse:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Estate Representative if Individual Implanted with Davol/C.R. Bard Hernia Mesh Device is Deceased:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. DAVOL/C.R. BARD HERNIA MESH DEVICE INFORMATION**

**Date of implant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason Davol/C.R. Bard Hernia Mesh Device was Implanted**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Davol/C.R. BardHernia Mesh Device**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Implanting Surgeon**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of implant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason Davol/C.R. Bard Hernia Mesh Device was Implanted**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Davol/C.R. Bard Hernia Mesh Device**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Implanting Surgeon**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For each Davol/C.R. Bard Hernia Mesh Device, attach the implant operative report and any medical evidence of product identification (product ID sticker); if available.***

**IV. DAVOL/C.R. BARD HERNIA MESH DEVICE**

**REMOVAL/REVISION SURGERY INFORMATION**

**Date of surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explanting surgeon**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explanting surgeon**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For each removal/revision, attach the operative report, any pathology report, and any medical evidence identifying the device removed/revised; if available.***

\*\*\*Attach additional pages as needed to identify other responsive implant or removal/revision procedures.

**V. OUTCOME ATTRIBUTED TO DEVICE**

**A. Plaintiff asserts the following injuries as a result of the Davol/C.R. Bard Hernia Mesh Device(s):**

Abscess(es)  Loss of testicle(s)

Adhesions  Mesh migration

Bowel/intestinal obstruction(s)  Mesh shrinkage

Bowel/intestinal perforation(s)  Nerve damage

Bowel/intestinal removal(s)  Other organ perforation(s)

Death  Pain & Suffering

Recurrence  Ring break

Fistulae  Seroma(s)

Infection(s)  Other (describe below)

\_\_\_\_\_

Please describe any additional information regarding Plaintiff’s physical injury(ies) that Plaintiff believes were caused as result of the Davol/C.R. Bard Hernia Mesh Device(s): \_ \_ \_ \_ \_ \_ \_ \_

**B. Please list all doctors or other healthcare providers Plaintiff has seen for treatment of any of the alleged injuries listed above.**

|  |  |  |
| --- | --- | --- |
| **Provider Name, Address, and Specialty** | **Condition Treated** | **Approximate Dates o**f  **Treatment** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

\*\*\*Attach additional pages as needed to describe injuries or identify other responsive health care providers.

**VI. MEDICAL HISTORY**

1. **Prior to the first Davol/C.R. Bard Hernia Mesh Device implant, has Plaintiff ever had:**

Diabetes:  **Yes**  **No**  **Unknown/Unsure**

Adhesions or Adhesive Disease:  **Yes**  **No**  **Unknown/Unsure**

Hernia and/or Prior Hernia Repair:  **Yes**  **No**  **Unknown/Unsure**

Irritable Bowel Syndrome:  **Yes**  **No**  **Unknown/Unsure**

Lupus:  **Yes**  **No**  **Unknown/Unsure**

Auto Immune Disorder:  **Yes**  **No**  **Unknown/Unsure**

Anemia or other blood disorder:  **Yes**  **No**  **Unknown/Unsure**

Respiratory disease (i.e. Emphysema and/or COPD):  **Yes**  **No**  **Unknown/Unsure**

Any disease of the gut, intestines, or bowels:  **Yes**  **No**  **Unknown/Unsure**

Any abdominal surgery(ies):  **Yes**  **No**  **Unknown/Unsure**

**With regard to cigarettes, Plaintiff is a:**

(PLEASE CHECK ONLY ONE)

Non-smoker

Current Smoker (please answer question 1 below)

1. How many packs a day does Plaintiff smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Smoker (please answer question 2 below)

2. Approximately when did Plaintiff quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VII. OTHER**

A. (1) Is Plaintiff claiming damages for lost wages:  **Yes**  **No**

(2) If so, for what time period(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. (1) In the past seven years has Plaintiff filed for bankruptcy:  **Yes**  **No**

(2) If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATIONS AND MEDICAL RECORDS TO BE PRODUCED**

Provide duly executed medical records authorization forms attached as Ex. A for all healthcare providers identified in Section V.B. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

Provide a copy of all medical records in your possession, custody, or control (including any medical records in your attorney’s possession) related to the claims and/or alleged injuries in this case.

Signed this\_\_\_\_\_\_Day of\_\_\_\_\_\_2019

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plaintiff’s Counsel of Record

Firm Name

Firm Address

Firm Address 2

Phone

Email