UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE: DAVOL, INC./C.R. BARD, INC., POLYPROPYLENE HERNIA MESH PRODUCTS LIABILITY LITIGATION

Case No. 2:18-md-2846

CHIEF JUDGE EDMUND A. SARGUS, JR.
Magistrate Judge Kimberly A. Jolson

This document relates to:

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)
- ☐ Adhesions
- ☐ Bowel/intestinal obstruction(s)
- ☐ Bowel/intestinal perforation(s)
- ☐ Bowel/intestinal removal(s)
- ☐ Death
- ☐ Recurrence
- ☐ Fistulae
- ☐ Infection(s)
- ☐ Loss of testicle(s)
- ☐ Mesh migration
- ☐ Mesh shrinkage
- ☐ Nerve damage
- ☐ Other organ perforation(s)
- ☐ Pain & Suffering
- ☐ Ring break
- ☐ Seroma(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 of Treatment

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

VI. MEDICAL HISTORY

A. 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

_____

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

TO: _____

Patient Name:_____ **SSN:**_____ **DOB:** _____

I,_____, hereby authorize you to release and furnish to: Reed Smith LLP and/or Litigation Management, Inc., 6000 Parkland Boulevard, Mayfield Heights OH 44124, copies of the following information:

- All records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, x-rays, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records created or received by you or other physicians or staff, as well as all autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

****Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR §164.501**.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. T h i s d o c u m e n t d o e s n o t a u t h o r i z e y o u t o discuss with any individual any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition. This document does not limit your ability to testify at deposition or trial about any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition.**

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire two years from the date of execution.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is <u>not</u> required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____ (plaintiff/representative)

Signature: _____ Date: _____