**UNITED STATES DISTRICT COURT**

**THE SOUTHERN DISTRICT OF OHIO**

**EASTERN DIVISION**

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| **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 FACT SHEET**

Those plaintiffs who have been selected, or in the future are selected, as a Bellwether Case and who allegedly suffered injury as a result of a DAVOL/BARD Hernia Mesh Device must complete this Plaintiff Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. Please answer every question to the best of your knowledge. Do not leave any blanks throughout this Fact Sheet. If you cannot recall all of the details requested, please provide as much information as you can and then state that your answer is incomplete and explain why as appropriate. If you select an “I Don’t Know” answer, please state all that you do know about that subject. If you do not have room in the space provided to complete an answer, please attach as many sheets of paper as necessary to fully answer the questions set out below. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can. If any of the information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory responses pursuant to Federal Rules of Civil Procedure 33 and 34 and will be governed by the standards applicable to written discovery under Federal Rules of Civil Procedure 26 through 37.

You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. Should you need to correct or supplement any response made here, please contact your attorneys, and they will assist you in doing so.

As used in this Plaintiff Fact Sheet, “Davol/Bard Hernia Mesh” and “Davol/Bard Hernia Mesh Device” refer to the medical device or devices identified in paragraph 7 of your Short Form Complaint or, if no Short Form Complaint has been filed in the individual action, the device identified as the device at issue in plaintiff’s operative complaint. In filling out this form, please use the following definition: “healthcare provider” means any doctor, physician, surgeon, pharmacist, hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

1. **CASE INFORMATION**
2. Name of person who received the DAVOL/BARD Hernia Mesh Device(s): \_\_\_\_\_\_\_\_\_\_\_
3. Name of Plaintiff (if different from above) and the relationship of the person completing this form to the person in I(A) above:
4. Provide the following information for the lawsuit that has been filed:
   1. Case caption:
   2. Civil action number:
5. If the person completing this Fact Sheet is doing so in a representative capacity (*e.g*., on

behalf of the estate of a deceased person, or on behalf of a minor), please provide the following (**otherwise skip to Section II**):

* 1. Your current address:
  2. State in what capacity you are representing the individual or estate (for example, as executor, as personal representative, etc.):

* 1. If you were appointed as a representative by a court, then state:
     1. Court that appointed you:
     2. Date of appointment:
  2. If you represent a decedent’s estate, then state:
     1. Decedent’s date of death:
     2. Home address of decedent at time of death:
     3. Your relationship to the deceased or represented person:
     4. If you represent a decedent, please attach a copy of the Decedent’s death certificate and autopsy report, if any.

1. Full name of the person completing this form, if different from the person listed in I(A), I(B) or I(D) above, and the relationship of the person completing this form to the person in I(A), I(B), or I(D)above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name, address, telephone number, fax number and email address of principal attorney representing you:

Name: Firm: Address:

Telephone Number: Fax Number:

E-mail Address:

# THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON

**WHO RECEIVED THE DAVOL/BARD HERNIA MESH DEVICE(S)**. Those questions using the term “You” refer to the person who received the DAVOL/BARD Hernia Mesh Device as identified in question I(A) above. Therefore, if you are completing this questionnaire in a representative capacity, please respond to the remaining questions as if they are asking about the person who received the DAVOL/BARD Hernia Mesh Device(s). If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.

# PERSONAL INFORMATION

1. Prefix (Mr., Ms., Rev., Dr., etc.): / First name: Last name: / Suffix (Sr., Jr., etc.): Middle name: Maiden name (if any):
2. Other names by which you have been known (from prior marriages or otherwise):
3. Male Female
4. Social Security number:
5. Date and place of birth:
6. Present home address:
   1. How long have you lived at this address?
   2. Identify the name and age of any person(s) who currently resides with you and their relationship to you:
7. Identify each prior home address where you have lived during the last 10 years:

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| --- | --- |
| **Prior Address** | **Dates You Lived At This Address** |
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1. Are you currently married? Yes No

# If Yes, please provide:

* 1. Spouse’s name:
  2. Spouse’s date of birth:
  3. Spouse’s occupation:
  4. Date of marriage:
  5. Were you married before this: Yes No

# If Yes, please tell us:

* + 1. Spouse’s name:
    2. Approximate dates of the marriage:
    3. Result of the marriage:

1. Identify all schools you attended, starting with high school:

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| --- | --- | --- | --- | --- |
| Name of School | Address | Dates of Attendance | Degree Awarded | Major or Primary Field |
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1. Please provide the following information for your employment history over the past 10 years. Note: If you are **not** claiming lost wages or lost earning capacity, you are **not** required to provide your salary or rate of compensation:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employer/Company | Address | Occupation/  Job Title | Dates of Employment | Salary /Rate  of Pay |
|  |  |  |  |  |
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1. At any time in the past 10 years have you missed work for more than 10 consecutive days for reasons related to your health and not due to a cold or flu? Yes No

# If No, skip to Part II.L., below.

# If Yes, for each such instance:

* 1. Provide the approximate dates of your absence from work:

* 1. Identify by name and address your employer at that time:
  2. Describe the health condition that prevented you from working, including whether/how the condition resolved such that you were allowed to return to work:

1. Have you ever served in any branch of the military? Yes No

# If No, skip to Part II.M, below.

# If Yes:

* 1. Branch and dates of service:
  2. If Yes, were you ever discharged for any reason relating to a medical or physical condition?
  3. If Yes, state what that condition was:

1. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes No

# If No, skip to Part II.N, below.

# If Yes:

* 1. Describe the reason(s) you were rejected from military service.

# IMPLANT/EXPLANT INFORMATION

1. Did you receive a DAVOL/BARD Hernia Mesh Device? Yes No

How many?

**Please give the following information for each DAVOL/BARD Hernia Mesh Device(s) you received or believe you may have received (attach additional sheets as necessary):**

* 1. The date the DAVOL/BARD Hernia Mesh Device(s) that you identified in your Plaintiff Profile Form was implanted in you:
  2. Provide the size, product code or model number, and lot number of the DAVOL/BARD Hernia Mesh Device(s) you received
  3. Describe the medical condition(s) for which you received the DAVOL/BARD Hernia Mesh Device(s):
  4. Identify who diagnosed you with that medical condition:
  5. Identify the doctor and hospital or other facility that implanted the DAVOL/BARD Hernia Mesh Device(s):
  6. Prior to implantation, were you given any written warnings, instructions, or other information regarding the DAVOL/BARD Hernia Mesh Device(s) and/or potential complications of your surgery? Yes No\_\_\_\_ I Don’t Know\_\_\_\_
     1. If Yes:
        1. Provide the approximate date you received the warnings, instructions, or other information.
        2. Identify by name, if you can, the person(s) who provided the warnings, instructions, or other information.
        3. Provide a copy in accordance of Doc Request X.B.7.
  7. Prior to implantation, were you given any oral warnings or instructions regarding the DAVOL/BARD Hernia Mesh Device(s) and/or potential complications of your surgery? Yes No\_\_\_\_ I Don’t Know\_\_\_\_\_
     1. If Yes:
        1. Provide the approximate date you received the warnings or instructions.
        2. Identify by name, if you can, the person(s) who provided the warnings or instructions.

1. Was the DAVOL/BARD Hernia Mesh Device(s) that you received removed in whole or in part? Yes \_\_\_\_ No \_\_\_\_ I Don’t Know\_\_\_\_\_

# If No, skip to Part III.C., below.

# If Yes:

* + 1. Did a healthcare professional advise you to have the DAVOL/BARD Hernia Mesh Device(s) removed in whole or in part prior to the actual removal surgery?

Yes No I Don’t Know \_\_\_\_

# If Yes:

* + - 1. Provide the date(s) that any healthcare professional advised you to have the DAVOL/BARD Hernia Mesh Device(s) removed in whole or in part:
      2. What reason did the healthcare professional give for his/her recommendation that the DAVOL/BARD Hernia Mesh Device(s) be removed?
      3. Identify by name and address the healthcare professional who advised you to have the DAVOL/BARD Hernia Mesh Device(s) removed in whole or in part:
    1. Provide the date(s) the DAVOL/BARD Hernia Mesh Device was removed in whole or in part:
    2. Identify by name and address the doctor, hospital, or other facility that removed the DAVOL/BARD Hernia Mesh Device(s) in whole or in part:

* + 1. Do you know the current location of your removed DAVOL/BARD Hernia Mesh Device(s)? Yes No\_\_\_\_ I Don’t Know

# If Yes:

* + - 1. Please identify who is in possession of your removed DAVOL/BARD Hernia Mesh Device(s):

# If No:

i. Do you know whether your DAVOL/BARD Hernia Mesh Device(s) was destroyed? Yes \_\_\_\_ No\_\_\_\_ I Don’t Know\_\_\_\_\_

If Yes, please tell us how you know it was destroyed and, if you know, who destroyed it:

* + 1. Has the explanted DAVOL/BARD Hernia Mesh Device(s) or other material been returned to Davol, Inc. or C.R. Bard, Inc.?

Yes No I Don’t Know

# If Yes:

* + - 1. Provide the date the DAVOL/BARD Hernia Mesh Device(s) or other materials were returned:
      2. Identify by name and address the person(s) who returned the removed DAVOL/BARD Hernia Mesh Device(s) or other materials:

* + - 1. Identify by name and address the person(s) who received the removed DAVOL/BARD Hernia Mesh Device(s) or other materials:

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1. **IF YOUR DAVOL/BARD HERNIA MESH DEVICE(S) HAS *NOT* BEEN REMOVED IN WHOLE OR IN PART**, please answer the following questions.
   * 1. Has any doctor or other health care professional advised you to have the DAVOL/BARD Hernia Mesh Device(s) removed?

Yes\_\_\_\_\_ No \_\_\_\_ I Don’t Know \_\_\_\_\_

# If Yes:

* + - 1. Provide the date that any doctor or other health care professional advised you to have the DAVOL/BARD Hernia Mesh Device(s) removed in whole or in part:
      2. What reason did the doctor or other health care professional give for his/her recommendation that the DAVOL/BARD Hernia Mesh Device(s) be removed?
      3. Identify by name and address the doctor or other health care professional who advised you to have the DAVOL/BARD Hernia Mesh Device(s) removed in whole or in part:
      4. Why have you not had the DAVOL/BARD Hernia Mesh Device(s) removed?

* + 1. Has any doctor or other health care professional advised you not to have the DAVOL/BARD Hernia Mesh Device(s) removed?

Yes\_\_\_\_\_ No \_\_ I Don’t Know \_\_\_\_\_

# If Yes:

* + - 1. Identify by name and address any doctor or other health care professional who has advised you not to have the DAVOL/BARD Hernia Mesh Device(s) removed:
      2. Provide the date you were so advised:
      3. What reason did the doctor or other healthcare professional give for his/her recommendation that the DAVOL/BARD Hernia Mesh Device(s) not be removed?
    1. Do you intend to have the DAVOL/BARD Hernia Mesh Device(s) removed?

Yes No I Don’t Know

# If Yes:

* + - 1. Provide the approximate date when it will be removed:
      2. Identify by name and address the doctor, hospital, or other facility that you intend will perform the removal surgery:

**IV. INJURIES/DAMAGES**

1. Do you claim that you suffered physical and/or bodily injury resulting from your use of the DAVOL/BARD Hernia Mesh Device? Yes­ No

# If No, skip to Part IV.B., below.

**If Yes, provide the following information:**

* 1. Please describe in detail your physical injury(ies) and/or bodily injury(ies) you claim were caused as result of your use of DAVOL/BARD Hernia Mesh Device(s):

2. When did you first attribute these bodily injuries to the DAVOL/BARD Hernia Mesh Device(s).

3. Are you currently experiencing any physical or bodily injuries as result of your DAVOL/BARD Hernia Mesh Device(s) Yes No \_\_\_

**If Yes**, please describe your current symptoms in detail if different than that which is set forth in Question B.1. above.

4. Are you currently seeing, or have you ever seen a doctor or healthcare provider

for the physical injuries and/or bodily injuries you claim in Section IV. A.1, above? Yes \_ No \_\_\_\_

**If Yes**, please list all doctors and healthcare providers you have seen for treatment of any of the physical injuries and/or bodily injuries you claim in Section IV. A.1., above.

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| --- | --- | --- | --- |
| **Provider Name and Address** | **Condition treated** | **Approx. Date of Medical Attention** | **Treatment Rendered** |
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1. Were you hospitalized at any time for the physical and/or bodily injury(ies) you suffered as a result of DAVOL/BARD Hernia Mesh Device(s)? Yes \_ No \_\_\_\_

**If Yes,** please provide the following:

|  |  |  |
| --- | --- | --- |
| **Hospital Name and Address** | **Condition Treated** | **Approximate Date(s) of Treatment** |
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1. Has any doctor attributed your physical and/or bodily injuries to the DAVOL/BARD Hernia Mesh Device(s)? Yes No I Don’t Know

# If Yes:

* + 1. Provide the approximate date that a doctor or other health care practitioner first advised you that these bodily injuries were attributed to the DAVOL/BARD Hernia Mesh Device(s) that you received:
    2. Identify by name and address the doctor, hospital, or other facility that attributed these bodily injuries or symptoms to your DAVOL/BARD Hernia Mesh Device(s):

1. Do you claim to have suffered any psychiatric or psychological injuries requiring medical treatment as a result of your implantation of the DAVOL/BARD Hernia Mesh Device(s)?

Yes No

# If No, skip to Part IV.C., below.

# If Yes:

* 1. Are you currently seeing, or have you seen, a psychiatrist, psychologist or any other mental healthcare professional as a result of your implantation of the DAVOL/BARD Hernia Mesh Device(s).

Yes No

* 1. Describe your psychiatric and/or psychological injuries as a result of your implantation of the DAVOL/BARD Hernia Mesh Device(s):
  2. Provide the following information for any doctor, psychiatrist, psychologist, or other mental health professional who has treated you or is now treating and/or advising you for your injuries:
     1. Dates of treatment:
     2. Name:
     3. Address:
  3. Has any doctor, psychiatrist, psychologist, or other mental health professional attributed these psychiatric and/or psychological injuries to the DAVOL/BARD Hernia Mesh Device(s)?

Yes No I Don’t Know

# If No, skip to Part IV.C., below.

# If Yes:

* + 1. Identify by name and address the doctor, hospital, or other facility that attributed these psychiatric and/or psychological injuries to your DAVOL/BARD Hernia Mesh Device(s):

1. Do you claim that you have experienced lost wages or lost earning capacity resulting from your use of the DAVOL/BARD Hernia Mesh Device(s)? Yes No

# If No, skip to Part IV.D., below.

# If Yes:

* 1. Identify the employer:
  2. State the approximate amount of time which you have lost from work as a result of the injuries you believe were caused by your use of the DAVOL/BARD Hernia Mesh Device(s)

* 1. State the approximate amount of lost income through your employment:

# [Attach additional sheets as necessary to provide the same information for any other lost income or lost earning capacity for any additional employers.]

1. Have you expended any out-of-pocket expenses as a result of your DAVOL/BARD Hernia Mesh Device(s)?

Yes No

# If Yes:

* 1. Please identify and itemize all out-of-pocket expenses you have incurred:

1. Was any portion of your surgery or any other medical procedures relating to your surgery or physical and/or bodily injury claimed herein covered by health insurance, Medicare or Medicaid?

Yes No\_\_\_\_ I Don’t Know\_\_\_\_\_

Do you have any outstanding bills for your medical care and treatment as a result of any injury(ies) and/or bodily injury(ies), including any surgery or any other medical procedures relating to your claims in this case, and the approximate amount owed.

Yes \_\_\_\_ No I Don’t Know\_\_\_\_\_

# PRIOR LEGAL AND CLAIM HISTORY INFORMATION

1. Have you ever filed a lawsuit other than the present suit, relating to any bodily injury within the past 10 years? Yes No

**If Yes**, please explain the nature of the case, where it was filed, the case number, and identify your lawyer:

1. Have you applied for workers’ compensation, social security, or state or federal disability benefits within the past 10years? Yes No

# If Yes, then as to each application, separately state:

* 1. Date (or year) of application:
  2. Type of benefits:
  3. Nature of claimed injury/disability:
  4. Period of disability:
  5. Amount awarded:
  6. Basis of your claim:
  7. Was claim denied? Yes No
  8. To what agency or company did you submit your application:

9. Claim/docket number, if applicable:

1. In the last 10 years, have you been convicted of, or pled guilty to, a felony and/or crime of fraud or dishonesty? Yes No

# If No, skip to Part III, below.

# If Yes:

* 1. Please set forth where, when and the felony and/or crime.

D. Have you filed for bankruptcy in the past 7 years?

## Yes \_\_\_\_\_ No

## If yes, identify the court in which the bankruptcy proceeding was filed, the date of the filing, the case number, and the current status:

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# MEDICAL BACKGROUND

1. Provide your current: Age / Height / Weight
2. At the time you received your first DAVOL/BARD Hernia Mesh Device, please state:

Your age / Your approximate weight

1. In chronological fashion, identify (1) any and all prior hernia surgeries and/or any surgeries where a permanent material was implanted in your body (other than sutures) and (2) all surgeries that you have undergone since 10 years before the date of the implantation of your first DAVOL/BARD Hernia Mesh Device:

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| --- | --- | --- |
| **Approx. Date** | **Description of Surgery** | **Doctor or Healthcare Provider Involved** |
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# [Attach additional sheets as necessary to provide the requested surgical information]

D. Other than the DAVOL/BARD Hernia Mesh Device(s) that is/are subject of your lawsuit, have you been implanted with any other hernia mesh products, biologic products for hernia repair, or absorbable products for hernia repair? Yes No

**If Yes,** please provide the following information:

a. Product Name(s):

b. Date of implantation procedure(s) and name and address of implanting doctor(s):

c. Condition(s) sought to be treated through placement of the product(s):

d. Whether the product(s) remain implanted inside of you today?

Yes No \_\_\_\_ Don’t Know\_\_\_\_

E. To the extent not already provided in the charts at Part VI.C. and Part VI.D., above, provide the name, address, and telephone number of every doctor, hospital, or other health care provider from which you have received medical or healthcare advice and/or treatment for the past 10 years, other than treatment for psychiatric and/or mental health related conditions unless you are asserting claims for said injuries under Section IV.B., above.

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| --- | --- | --- |
| Name and Specialty | Address | Approx. Dates/Years  of Visits |
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F. **Other than what you are claiming as your INJURIES related to your DAVOL/BARD Hernia Mesh Device(s),** to the best of your knowledge, over the past 20 years have you been told by a doctor or any other health care provider, that you have suffered, may have suffered, or presently do suffer from any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Hernias (other than the one you repaired with DAVOL/BARD Hernia Mesh Device(s)) | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Recurrent Hernia(s) | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Recurrent or Chronic Infections | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Specify location and nature of infection:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Fistulas | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Adhesions | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Bowel Obstruction | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Bowel Perforation | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Peritonitis/Sepsis | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Malnutrition | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Anemia | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Chronic Obstructive Pulmonary Disease (COPD) | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Emphysema | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Connective Tissue Disorder | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Collagen Disorder | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Aneurysm | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Muscle or Muscle-Wasting Disorder | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Specify condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Hypertension or high blood pressure | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Hypotension or low blood pressure | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Obesity | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Heart Attack or Congestive Heart Failure | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Stroke | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Diabetes | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Thyroid dysfunction | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Crohn’s disease | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Irritable bowel syndrome | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Diverticulitis | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Any other disease of the gut, intestines, or bowel | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Specify condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Neuromuscular disease or disorder | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | Specify condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Immune system disease or dysfunction | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Any alcohol or chemical dependency addiction | Yes \_\_\_\_\_\_ | No \_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | If yes, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | Any history of tobacco use | Yes \_\_\_\_\_\_ | No \_\_\_\_\_\_\_ | Unsure \_\_\_\_\_\_\_ |
|  | If yes, specify type (cigarettes, cigars, chewing tobacco, frequency, when started and when quit, if applicable: \_  \_\_  \_  \_ | | | |

1. To the extent not previously disclosed in response to Part IV, above, list each prescription medication you have taken regularly for the past ten 10 years. Note, “regularly” shall be defined to mean for at least 60 days. Please include the reason you took the medication, and the dosage other than treatment for psychiatric and/or mental health related conditions unless you are asserting claims for said injuries under Section IV.B., above.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Reason for Medication** |
|  |  |  |
|  |  |  |
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# INSURANCE INFORMATION

1. Provide the following information for any past or present medical insurance coverage within the last 10 years:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Insurance Company | Policy Number | Name of Policy Holder/Insured (if different than you) | Approx. Dates of Coverage |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

B. To the best of your knowledge, have you been approved to receive or are you receiving

Medicare benefits due to age, disability, condition or any other reason or basis?

Yes \_\_\_No

**If Yes**, please specify the following:

a) The date on which you first became eligible:

C. To the best of your knowledge, have you been approved to receive or are you receiving

Medicaid benefits?

Yes \_\_\_No

*[Please note: if you are not currently a Medicare/Medicaid-eligible beneficiary, but become eligible for Medicare/Medicaid during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare/Medicaid regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]*

1. **COMMUNICATIONS WITH DEFENDANTS**
2. Have you or anyone acting on your behalf that you are aware of, other than your attorney or your healthcare professionals, ever communicated directly with Davol, Inc. or C.R. Bard, Inc. in any way concerning the DAVOL/BARD Hernia Mesh Device(s)?

Yes No I Don’t Know

# If No, skip to Part VII.B., below.

# If Yes:

* 1. Provide the date of any communication:
  2. Identify by name and address the person making the communication:
  3. Identify by name and address the person with whom you (or anyone else) communicated at Davol, Inc. and/or C.R. Bard, Inc.:
  4. Describe the method of communication (e.g., telephone, letter, e-mail, etc.):
  5. Describe the substance of the communication:

1. To your knowledge, have you or anyone acting on your behalf, that you are aware of, other than your attorney ever received a communication directly from Davol, Inc. and/or C.R. Bard, Inc. in any way concerning the DAVOL/BARD Hernia Mesh Device(s)?

Yes No I Don’t Know

# If No or I Don’t Know, skip to Part VIII, below.

# If Yes:

* 1. Provide the date of any communication:
  2. Identify by name and address the person with Davol, Inc. and/or C.R. Bard, Inc. making the communication:
  3. Identify by name and address the person to whom the communication from Davol, Inc. and/or C.R. Bard, Inc. was directed:
  4. Describe the method of communication (*e.g*., telephone, letter, e-mail, etc.):

* 1. Describe the substance of the communication from Davol, Inc. and/or C.R. Bard, Inc.:

# POTENTIAL WITNESSES

A. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you.

Name: Address:

Relationship to you:

Name: Address:

Relationship to you:

Name: Address:

Relationship to you:

Attach Additional Sheets if Necessary.

1. Have you received any money (or a promise of money to you in the future or a promise to pay some third party) from a lender or other third party in exchange for an assignment of any portion of your recovery in this lawsuit, such that the lender or assignee has decision making authority over the terms of any resolution of your claim?

Yes\_\_\_\_ No

If Yes, please state:

a. The name, address, telephone number, and email address of the lender and/or any third party involved in the legal funding:

**X. LOSS OF CONSORTIUM CLAIM**

1. Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the DAVOL/BARD Hernia Mesh Device(s)? Yes No

# If No, skip to Part XI, below.

# If Yes:

* 1. Identify by name and address the person who filed the loss of consortium claim:
  2. State that person’s relationship to you:
  3. Describe/Identify the damages suffered by consortium plaintiff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Please list the name and address of any healthcare providers the consortium plaintiff has seen for treatment for any injuries or alleged to be related to the loss of consortium claim.

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# AUTHORIZATIONS FOR RECORDS & DOCUMENT PRODUCTION

1. **AUTHORIZATIONS.**

**NOTE: Please sign and attach to this Fact Sheet the necessary authorization(s) for the release of the following records as applicable**

**1. Authorization for the release of medical records: please sign and fill out this authorization for all healthcare providers identified in Sections IV.A.4, IV.A.5, VI.C, VI.E.**

**2. Authorization for the release of psychiatric/Mental Healthcare records: please sign and fill out this authorization *only* if you are claiming psychiatric and/or mental health injuries as set forth in Section IV.B, and if so, please fill out and execute this authorization on behalf of all mental healthcare providers identified in Section IV.A.B.4.**

**3. Authorization for the release of Workers Compensation records: please sign and fill out this authorization *only* if you have identified a Workers’ Compensation claim in the prior 10 years pursuant to Section V.B.**

**4. Authorization for the release of Social Security Disability records: please sign and fill out this authorization *only* if you have received Social Security Disability benefits in past 10 years, as set forth in Section V.B.**

**5. Authorization for the release of Insurance records: please sign and fill out this authorization all insurance providers identified in Section VII.A.**

**6. Authorization for the release of Medicare records: please sign and fill out this authorization *only* if you have received Medicare in past 10 years, as set forth in Section VII.B.**

**7. Authorization for the release of Medicaid records: please sign and fill out this authorization *only* if you received Medicaid benefits in the past 10 years as set forth in Section VII.C.**

**8. Authorization for the release of employment records: please sign and fill out this authorization *only* if you are seeking lost wages or lost earnings capacity as set forth in Section IV.C., and if so, please fill out and execute this authorization on behalf of all employers identified in Section II.J.**

1. **DOCUMENTS**. State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents with this completed Fact Sheet.
   1. If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.
      1. Not Applicable
      2. The documents are attached [OR] I have no documents
   2. If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent’s death certificate.
      1. Not Applicable
      2. The documents are attached [OR] I have no documents
   3. Produce all documents in your possession, custody or control concerning any occasion on which you saw a doctor or other health care provider regarding any injury or physical or psychological complaint for which you claim compensation in this lawsuit, including but not limited to all medical reports and records; and laboratory findings and reports. If you answered Yes, in Section IVB, above, please also include psychological/psychiatric assessments and/or any psychiatric or mental health records in your possession, custody or control.
      1. The documents are attached [OR] I have no documents
   4. Produce all medical and hospital bills or receipts, and documents in your possession, custody or control reflecting any and all payments made for same, including, but not limited to, any hospital and health care professional bills incurred because of the injuries you allege you have incurred as a result of your use of the DAVOL/BARD Hernia Mesh Device(s).
      1. The documents are attached [OR] I have no documents
   5. Produce any communications in your possession, custody or control, excluding communications with your lawyers, concerning the DAVOL/BARD Hernia Mesh Device(s), including but not limited to e-mails, blogs, newsletters, etc.
      1. The documents are attached [OR] I have no documents
   6. Produce any notes, diaries, or other documents evidencing your physical condition from the earlier of the date of implant of your first Davol/Bard Hernia Mesh Device(s) or 10 years ago, including but not limited to the injuries for which you seek relief in this lawsuit.
      1. The documents are attached [OR] I have no documents
   7. Produce any DAVOL/BARD Hernia Mesh packaging, labeling, advertising, or any other DAVOL/BARD Hernia Mesh-related items in your possession, custody or control.
      1. The documents are attached [OR] I have no documents
   8. Produce all documents in your possession, custody or control evidencing or relating to any correspondence or communication between Davol, Inc. or C.R. Bard, Inc. and any of your doctors, healthcare providers, and/or you relating to the DAVOL/BARD Hernia Mesh.
      1. The documents are attached [OR] I have no documents
   9. Produce any and all documents in your possession, custody or control relating to the recall of the DAVOL/BARD Hernia Mesh that you received and/or reviewed at any time prior to filing this lawsuit.
      1. The documents are attached [OR] I have no documents
   10. Produce any and all documents in your possession, custody or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of the DAVOL/BARD Hernia Mesh concerning the risks and/or benefits of your hernia repair surgery, including but not limited to any risks and/or benefits associated with the DAVOL/BARD Hernia.
       1. The documents are attached [OR] I have no documents
   11. Produce any and all documents reflecting the size, model number, and lot number of the DAVOL/BARD Hernia Mesh you received.
       1. The documents are attached [OR] I have no documents
   12. If you underwent surgery to remove in whole or in part the DAVOL/BARD Hernia Mesh Device(s) that you received, produce any and all documents in your possession, custody or control relating to any evaluation of the DAVOL/BARD Hernia Mesh and any other material that was (were) surgically removed from you.
       1. The documents are attached [OR] I have no documents
   13. Produce all documents in your possession, custody or control relating to any responses to the workers compensation questions above.
       1. The documents are attached [OR] I have no documents \_\_
   14. Produce all documents in your possession, custody or control relating to any responses to the bankruptcy questions above.
       1. The documents are attached [OR] I have no documents
       2. If you claim lost wages or lost earning capacity, copies of your W-2 and any other evidence you will use to support your claim for lost wages or lost earning capacity for the two years prior to this lawsuit. The documents are attached [OR] I have no documents

15. All documents in your possession, custody or control concerning payment by

Medicare on the injured party's behalf relating to the injuries claimed in this lawsuit, including but not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on your behalf for medical expenses relating to the subject of this litigation.

1. The documents are attached [OR] I have no documents

16. **IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY**

**STORED INFORMATION:** For the period beginning three years prior to implantation of the DAVOL/BARD Hernia Mesh Device(s) to present, please describe any research, including on-line research, you have conducted regarding the device(s) and injuries that are the subject of your lawsuit, including the implantation of the hernia mesh device(s), the injuries and/or damages you claim resulted from the implantation of the DAVOL/BARD Hernia Mesh Device(s), or your medical or physical condition related to injuries you claim resulted from the implantation of the DAVOL/BARD Hernia Mesh Device(s). To the best of Plaintiff’s ability, he or she should identify the date such research was conducted and the name of any websites visited. Research conducted to identify or evaluate potential counsel or legal representation or to understand the legal and strategic advice of your counsel is not considered responsive to this request.

# SWORN DECLARATION

Plaintiff, , deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in Part XI of this Fact Sheet to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Fact Sheet.

Dated:

Signature of Plaintiff

# SWORN DECLARATION

# (FOR CONSORTIUM PLAINTIFF)

To the extent a loss of consortium claim is being asserted, and Section X, above has been completed, the following Declaration is being made by the Consortium Plaintiff and this Declaration applies to Section X, of this Fact Sheet only.

Plaintiff, , deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Fact Sheet regarding my loss of consortium claim is true and correct to the best of my knowledge, information and belief.

Dated:

Signature of Consortium Plaintiff