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BRIAN R. MARTINOTTI, J.S.C.

IN RE DEPUY ASR™ HIP IMPLANTS LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY CASE CODE 293 MASTER DOCKET NO.: BER-L-3971-11 CIVIL ACTION
This Document Relates to All Actions	**CASE MANAGEMENT ORDER NO. 18**

It is hereby ordered that any Plaintiff with a case pending in the above referenced litigation shall complete and serve an ASR Supplemental Plaintiff Disclosure Form, attached as Exhibit A to this Order, by March 30, 2013. The ASR Supplemental Plaintiff Disclosure Form shall be served on Plaintiffs' Liaison Counsel and Defendants' Counsel, via first class or overnight mail, as follows:

David R. Buchanan, Esq.
Seeger Weiss, LLP
550 Broad Street
Newark, NJ 07102
Plaintiffs' Liaison Counsel

Lauren D. Godfrey, Esq.
Drinker Biddle & Reath, LLP
500 Campus Drive
Florham Park, NJ 07932
Defendants' Counsel

Each Plaintiff is required to provide authorizations for the release of medical records for medical providers identified in the ASR Supplemental Plaintiff Disclosure Form by March 30, 2013, if authorizations for those providers have not been previously provided in response to the Plaintiff Fact Sheet. The authorizations for release of medical records shall be in the form provided and attached to the Plaintiff Fact Sheet as Exhibit B.

This ASR Supplemental Plaintiff Disclosure Form must be completed and served regardless of whether a Plaintiff has previously served a Plaintiff Preliminary Disclosure Form or a Plaintiff Fact Sheet – it is a separate and independent form and must be completed. This Form is not a verified discovery response and is not evidence, but is designed to obtain information the Court finds necessary to assess the need for future discovery.

All Plaintiffs have a continuing duty to serve an updated form. The next date by which updated forms are due is October 15, 2013.

HON. BRIAN R. MARTINOTTI, J.S.C.

ASR SUPPLEMENTAL PLAINTIFF DISCLOSURE FORM

1. (a) Name _____
First Middle Last

(b) DOB: _____
(Please format as MM/DD/YYYY)

(c) Address _____
Street

_____ _____ _____
City State (Abbreviation) Zip Code

(d) Venue: _____
(Please list two letter state abbreviation, followed by judicial district and division.)

(e) Attorney: _____

2. Have you had an ASR hip implant? Yes ___ No ___. (Please mark one response with X.). Have you had an ASR hip implant for both hips? Yes ___ No ___. (Please mark one response with X.) If yes, please answer No. 2 for both sides.

(a) Implant Date (Left): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

(b) Implant Date (Right): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

3. Have you had a revision on either side? Yes ___ No ___. (Please mark one response with X). If yes, please answer No. 3.If you had a bilateral, answer No. 3 for both sides. Revision date is the date you had a second surgery on the hip with the ASR implant.

(a) Revision Date (Left): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

(b) Revision Date (Right): _____
(Please format as MM/DD/YYYY)

Hospital _____

Surgeon _____
First Middle Last

4. If you have not had a revision yet, but one is scheduled, provide the date: _____(DATE)
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

5. Has your doctor recommended a revision or re-revision, but also advised you that this surgery is medically contraindicated and/or would be life threatening? Yes ___ No ___ (Please mark one response with X.)

If so, identify the name and address of the doctor, the date of the discussion, and the medical condition which prevents you from having the surgery and state whether you have been advised that this condition will permanently prevent you from having revision surgery, as opposed to delaying a revision surgery.

Date(s) of Discussion: _____
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

Doctor _____
First Middle Last

Address _____
Street

_____ _____ _____
City State (Abbreviation) Zip Code

Medical condition: _____
(Please use semi colon to separate distinct medical conditions.)

Medical Condition Permanently Prevents Revision? Yes ___ No ___ (Please mark one response with X.)

6. Do you claim that your **revision surgery** led to any of the following: Yes ___ No ___ (Please mark one response with X.)
(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon)

(a) A second revision _____ (DATE)

(b) A third revision _____ (DATE)

(c) A fourth revision _____ (DATE)

(d) Death _____ (DATE)

(e) Heart Attack _____ (DATE)

(f) Stroke _____ (DATE)

(g) Pulmonary Embolism _____ (DATE)

(h) Deep Vein Thrombosis _____ (DATE)

(i) Dislocation: Yes ___ No ___ (Please mark one response with X.) Number of Dislocations: _____

Please provide the DATE(S) of any dislocations: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon. For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

(j) Infection(s): Yes ___ No ___ (Please mark one response with X.)

Please provide the DATE(S) of any infections: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon. For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

If you marked yes for infection, please mark an X for any and all of the following treatment received:

IV antibiotic treatment ___ Antibiotic spacers ___ Irrigation & Debridement ___

(k) Permanent and Full Time use of a wheel chair or walker for ambulation (not used prior to revision surgery)

Yes ___ No ___ (Please mark one response with X.)

(l) Foot drop: Yes ___ No ___ (Please mark one response with X.)

If you marked yes for foot drop, please identify the treatment received or recommended:

_____

_____

7. Have you had any other hip surgery post-revision (not already identified above) that you claim is related to the revision? Only answer yes if you have undergone surgery. Do not answer yes if you have only received injections.

Yes ___ No ___ (Please mark one response with X.)

Please state the condition treated: _____

_____

Please provide the DATE(S) of any additional surgeries: _____

(Please format as MM/DD/YYYY, separating multiple dates with a semi-colon (;). For any case with bilateral implants, please designate which hip with a (L) or (R) following the date.)

(Do not include in your response to this question any revision surgery where one or more hip implant parts were removed and replaced or any reduction for a dislocation.)

To the extent you have not already provided authorizations with a previously submitted Plaintiff Fact Sheet (PFS), provide signed authorizations for any doctor or medical provider who has treated you for any condition identified in Questions 4, 5, 6 and 7 above.