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JOHNSON & JOHNSON

FILED
SEP 28 2011
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 CIVIL ACTION
This Document Relates to All Actions	**CASE MANAGEMENT ORDER NO. 8**

THIS MATTER having been opened to the Court by lead counsel for the parties, and the parties consenting to the form, substance and entry of the Order, and for good cause shown,

IT IS on this 28 day of September 2011;

ORDERED as follows:

I. SCOPE OF THE ORDER

This Order applies to all DePuy ASR™ Hip Implant Products Litigation actions centralized for coordinated management in the Bergen County Vicinage and all those hereinafter filed or transferred to the Bergen County Vicinage pursuant to the Supreme Court Order dated April 12, 2011.

II. PLAINTIFF FACT SHEETS

1. The Court hereby approves with the consent of the parties the "Plaintiff Fact Sheet" (PFS) attached as Exhibit A and the medical records authorization attached as Exhibit B.

2. Each Plaintiff in a DePuy ASR™ Hip Implant Products Litigation action who has undergone revision surgery shall complete and serve a completed PFS.

3. In addition, each Plaintiff in a DePuy ASR™ Hip Implant Products Litigation action who has undergone revision surgery shall complete and serve medical record authorizations for all health care providers identified in the PFS in the form attached hereto as Exhibit B. The PFS and authorizations shall be served on Defendants' Counsel. Service of the PFS, authorizations and responsive documents shall be in an electronic format on CD via first class or overnight mail, addressed to:

ASR Plaintiff Fact Sheet
c/o Lauren D. Godfrey, Esq.
Drinker Biddle & Reath LLP
500 Campus Drive
Florham Park, NJ 07932

4. For cases currently pending before the Court, the PFS and authorizations for each Plaintiff who has undergone revision surgery shall be served no later than 90 days from the date of this Order. Plaintiff must also provide along with the PFS all responsive non-privileged documents in his or her possession requested in the PFS.

5. For all cases transferred to or direct-filed in this Court after the date of this Order, the PFS and authorizations for each Plaintiff who has undergone revision surgery shall be served no later than 90 days from the date a case is transferred to or direct-filed in this Court to complete and serve the PFS and authorizations.

6. Each Plaintiff who undergoes revision surgery at some point after filing suit shall complete and serve a PFS and authorizations as set forth above no later than 120 days from the date of the revision surgery. Plaintiff must also provide along with the PFS all responsive non-privileged documents in his or her possession requested in the PFS.

7. A Plaintiff who is not obligated to complete a PFS may nevertheless voluntarily choose to complete a PFS and produce the required documents and authorizations.

8. Nothing in the PFS shall be deemed to limit the scope of inquiry at depositions and admissibility of evidence at trial. The scope of inquiry at depositions shall remain governed by the New Jersey Rules of Court. The admissibility of information in the PFS shall be governed by the Rules of Court, and no objections are waived by virtue of any fact sheet response.

9. The parties may agree to an extension of the above time limits for service of the PFS. Consideration should be given to requests for extensions to stagger PFS deadlines where a single law firm has a large number due on or near the same dates. If the parties cannot agree on reasonable extensions of time, such party may apply to the Court for such relief upon a showing of good cause.

IT IS SO ORDERED.

BRIAN R. MARTINOTTI, J.S.C.

DC01/ 2784428.1

EXHIBIT A

IN RE DEPUY ASR™ HIP IMPLANTS LITIGATION	:	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: BERGEN COUNTY CASE CODE 293 CIVIL ACTION

PLAINTIFF FACT SHEET (Long Form)

Please provide the following information for each individual on whose behalf a claim is being made. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who had the DePuy ASR™ Hip Resurfacing System and the ASR™ XL Acetabular System (the "Device") implanted. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, please assume that "You" means the person who had the Device implanted. In filling out this form please use the following definition: "healthcare provider" means any 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, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement your responses to provide that information as soon as you become aware of this information. This form requests information and documents about your medical condition for a specified period of time. However, defendants reserve the right to request additional information and information for a time period dating further back on a case by case basis, at which time the parties will meet and confer as the issue arises.

In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney if you have any questions regarding the completion of this form.[1]

[1] This Plaintiff Fact Sheet constitutes discovery responses subject to the Federal Rules of Civil Procedure, JCCP, and New Jersey Rules of the Court.

I. CASE INFORMATION

1. Name of person completing this form: _____

2. Name of person on whose behalf a claim is being made: _____

3. Please state the following for the civil action that you filed:

   a. Case caption: _____
   b. Docket Number: _____
   c. Court in which action was originally filed: _____
   d. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:
      Name: _____
      Firm: _____
      Address: _____
      Telephone Number: _____
      Fax Number: _____
      E-mail Address: _____

4. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:

   a. Your name, including other names you have used or by which you have been known and dates you used those names:

      _____

   b. Current Address: _____

   c. In what capacity are you representing the individual or estate: _____

   d. If you were appointed as a representative by a court, state the:

      Court which appointed you: _____

      Date of appointment: _____

   e. What is your relationship to the individual you represent: _____

      _____

   f. If you represent a decedent's estate, state:

      Date of Death: _____

THE REST OF THIS PLAINTIFF FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO WAS IMPLANTED WITH THE DEVICE

II. CORE INFORMATION

1. Type of ASR Prosthesis: _____

   Side of body: right left both (please circle one)

Complete the questions in this section for each implantation surgery involving an ASR product.

2. Product Code/Lot Code for each Device (please attach a copy of the stickers shown on the operative report) _____

   _____

   _____

3. Dates of Implantation: _____

4. Name and Address of Implanting Surgeon(s): _____

   _____

   _____

5. Name and Address of Hospital or Clinic where surgery(ies) performed: _____

   _____

6. If the Device(s) has been removed, provide the date on which it was removed: _____

   _____

7. Name and Address of Surgeon(s) who removed the Device(s): _____

   _____

8. Name and Address of Hospital or Clinic where surgery(ies) performed: _____

   _____

9. Name of the Manufacturer and size of the replacement device, if any: _____

   _____

   _____

10. a. Did you pay for your revision surgery and all related care?

Yes ___ No ___ In Part ___

b. If No or In Part, state who or who else paid for the revision surgery:

_____

_____

Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, and for carriers, provide the name, address, and policy number.

_____

_____

_____

c. Did you pay for your initial surgery and all related care and all related care?

Yes ___ No ___ In Part ___

d. If No, or In Part, state who or who else paid for the surgery and all related care:

_____

_____

Provide the approximate amount paid by each person and entity and identify each person and insurance carrier, and for carriers, provide the name, address, and policy number.

_____

_____

_____

11. Were any of the components of the Device surgically removed? Yes _____ No_____

a. If Yes, what is the present location of the removed components of the Device?

_____

12. If you have not had any components of your Device removed surgically, do you presently plan to have any of the components removed ? Yes _____ No____ undecided_____

If Yes, please state:

The date scheduled for the surgery to remove/replace the Devices: _____

_____

The name of the surgeon: _____

_____

The name and address of the hospital where the surgery will be performed: _____

_____

The reason for the surgery: _____

_____

13. Has any doctor ever told you that you need to have any components of your Device removed? Yes _____ No _____

If Yes, please provide name and address of each such doctor:

_____

_____

14. Has any doctor told you that your medical condition prevents you from having any components of your Device removed ? Yes _____ No _____

If Yes, please provide name and address of each such doctor:

_____

_____

15. Have you received any other treatment or testing related to your Device after learning about the recall?

Yes _____ No _____

If Yes, please state:

Date	Facility Name	Address and Telephone Number	Reason	Results

III. PERSONAL INFORMATION

1. Name (first, middle name or initial, last): _____

2. Maiden or other names used and dates you used those names:

_____

3. Current address and date when you began living at this address:

_____

4. Identify each address at which you resided for the period from five years before your first hip surgery up to the present and the dates you resided at each one.

Address	Dates of Residence

5. Social Security Number: _____

6. Date and place of birth: _____

7. Current marital status: _____

8. If married, please provide the following information:

Date of marriage: _____

Name of spouse: _____

Date and place of birth of spouse: _____

9. If married, has your spouse filed a loss of consortium or other claim in this action?

Yes _____ No _____

10. Name(s) of former spouse(s), date(s) of marriage(s) and dates the marriage(s) were terminated, and the nature of the termination (i.e., death, divorce):

_____

_____

11. If you have children, list each child's name and date of birth.

_____

_____

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

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field

13. Are you currently employed? Yes _____ No _____

If yes, please identify your current employer with name, address and telephone number and your position there: _____

_____

If not, did you leave your last job for a medical reason? Yes _____ No _____

If Yes, describe why you left:

_____

14. For the period of time from five years before your had your first hip surgery, until the present, please identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	**Address and Telephone Number**	**Dates of Employment**	**Describe Your Position or Duties and Specify if Job Required Manual Labor**	**Reason for Leaving**

15. For the period from five years before your first hip surgery until the present, please indicate if you have actively participated in any sports:

Yes _____ No _____

If Yes, please state:

Type of Sport	**Dates/Years played**	**Approximate number of hours you played per week**	**Approximate number of hours you practiced per week**

16. For the period from five years before your first hip surgery until the present, please indicate if you have regularly exercised:

Yes _____ No _____

If Yes, please state:

Type of Exercise	Dates/Years Exercised	Approximate Number of hours You exercised per week	Period of times during which you performed this exercise (month/year)

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

Branch and dates of service: _____

If Yes, were you ever discharged for any reason relating to your medical or physical condition? _____

If Yes, state what that condition was:_____

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

If Yes, state what that condition was:_____

18. If you have Medicare, please state your HICN number: _____

19. For the period from five years before your first hip surgery to the present, have you been on or applied for workers' compensation, social security, and/or state or federal disability benefits? Yes _____ No _____

If Yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

a. Date (or year) of application: _____

b. Type of benefits:_____

c. Nature of claimed injury/disability: _____

d. Period of disability:_____

e. Amount awarded:_____

f. Basis of your claim:_____

g. Was claim denied? Yes _____ No _____

h. To what agency or company did you submit your application: _____

_____

i. Claim/docket number, if applicable:_____

20. Have you ever been involved in an accident or event, in which or as a result of which you suffered any personal injuries to your legs, hips or pelvic area? Yes___ No___

If Yes, please provide the following information and attach copies of any accident reports:

Place and Date of Accident	**Circumstances, Nature, Location, and Extent of Injury**	**Nature of Activity at Time of Injury**	**Names and Addresses of Treating Physician(s)**

21. a. Have you ever filed a lawsuit or made a claim against a healthcare provider or pharmaceutical company? Yes _____ No _____

b. Have you ever filed a lawsuit or made a claim against anyone related to any injury to your hip, pelvis or legs? Yes _____ No _____

If Yes to either (a) or (b) above, please provide the following information and attach copies of all pleadings, releases or settlement agreements and deposition transcripts you have:

Party You Sued/Made Claim Against	Court in Which Suit Filed/Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

22. Have you ever been convicted of, or pled guilty to, a felony within the past ten years? Yes _____ No _____

    If Yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending:_____

    _____

23. Have you or your spouse ever declared bankruptcy since the date of your original hip implantation surgery? Yes _____ No _____

    If Yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the orders of discharge:_____

24. Have you or your spouse (if he/she is pursuing a loss of consortium claim) received any money from a third party in exchange for an assignment of any portion of your claim or recovery in this lawsuit, so that the payer or assignee has decision making authority over the terms of any settlement or other resolution of your claim or has lien rights (excluding liens by healthcare providers) against any funds generated by the resolution of your claim?

    Yes _____ No _____

    If Yes, please state:

    The name and address of the third party with whom you have entered into such a contract. _____

    _____

25. Since you received your ASR hip prosthesis, have you publicly posted a comment, message or blog entry on a public internet site (e.g. no password required for access) in which you have discussed or described your ASR experience, injury, disability, pain or physical complaints related to the ASR hip? (You should include non-password protected postings on public social network site including Twitter, Facebook, MySpace, Linked In, or "blogs" where the general public may post ASR related comments).

Yes _____ No _____

If so, please tell us where and when you made such public posts and the substance of what was posted. Do not include postings that were provided exclusively to your attorney or his/her representative.

_____

_____

_____

_____

_____

IV. HEALTHCARE PROVIDERS

FOR ALL QUESTIONS IN THIS SECTION, MEN DO NOT HAVE TO PROVIDE DETAILS AS TO PROSTATE CONDITIONS, AND WOMEN DO NOT HAVE TO PROVIDE INFORMATION AS TO BIRTH CONTROL OR REPRODUCTIVE ISSUES (UNLESS THERE IS A CLAIM RELATED TO CHILD BEARING, AND THEN A FULL OBSTETRICAL AND GYNECOLOGIC HISTORY NEEDS TO BE PROVIDED).

1. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, orthopedic surgeons, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment for the period five years before your first hip surgery to the present. (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name and Specialty	Address and Telephone Number	Approx Dates/Years of Visits	Reason

2. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) for the period five years before your first hip surgery to the present. (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name	Address	Admission Date(s)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

3. Identify each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans) were taken in the last 10 years of your hips, pelvis or legs.

Name	Address and Telephone Number	Approx Date Taken	Reason

4. Identify each laboratory at which your blood was tested in the last 10 years for blood levels of any metals including cobalt and chromium.

Name	Address and Telephone Number	Approx Date Taken	Reason	Results (if known by you)

5. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period five years before your first hip surgery to the present. (except for medicine for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx Dates/Years You Used Pharmacy/Supplier

V. MEDICAL BACKGROUND

1. Current Height:_____

2. Please state your weight at the following times:

   a. Current:_____

   b. Time of implant:_____

   c. Time of revision surgery (if any):_____

3. Smoking History

   a. Have you ever smoked cigarettes? Yes _____ No _____

   State brand(s) smoked: _____

   State amount smoked: _____ packs per day for _____ years, during the years

   _____ to _____.

   b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

   Yes _____ No _____

   State brand(s) smoked or chewed: _____

   State amount smoked/utilized: _____ cigars/pipes/smokeless tobacco per day for

   _____ years, during the years _____ to _____.

4. Alcohol/Drug Use

   a. For the period of time five years before your first hip surgery up to the present, set forth the amount and type(s) of alcoholic beverages you consume(d) on a weekly/monthly/yearly basis on average and the type. If the amount has materially changed over this period of time, please describe/explain.

   _____

   _____

   _____

b. For the period of time five years before your first hip surgery up to the present, have you taken cocaine, crack, heroin, LSD, or amphetamines?

Yes _____ No _____

If Yes, identify which drug(s), amount and period of use : _____

_____

5. Allergies and Allergic Reactions

a. Have you ever experienced an allergic reaction to any food, medication, jewelry, or metal?

Yes _____ No _____ If Yes, please state the following:

Food, Medication, Jewelry or Metal	**When Allergy Diagnosed**	**Symptoms of Allergy**	**Health Care Provider Who Diagnosed Allergy**	**Treatment Received, if any**

6. Other Conditions

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from the time beginning five years before your first hip surgery to the present? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	**Yes**	**No**	**Don't Know**
1. Arthritis (e.g., osteoarthritis, traumatic arthritis, rheumatoid arthritis, degenerative arthritis)			
2. Neuromuscular compromise or vascular deficiency			
3. Poor bone quality (e.g., osteoporosis)			
4. Charcot's or Paget's disease			
5. Cancer (including blood cancers such as leukemia)			

Condition Experienced or Diagnosed	Yes	No	Don't Know
6. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs or other substances, including allergic reactions to metal			
7. Obesity			
8. Alcohol or drug addiction			
9. Any pathological condition of the acetabulum (e.g., arthrokatadysis)			
10. Diabetes			
11. Infections lasting longer than a week or occurring more frequently than monthly			
12. Tumors or Pseudo-tumors			
13. Periarticular calcification or ossification			
14. Disabilities of joints (knees and ankles)			
15. Osteolysis			
16. Congenital dysplasia of the hip or subluxation or dislocation of the hip joint			
17. Peripheral neuropathies or nerve damage			
18. Acetabular perforation			
19. Femoral shaft perforation, fissure, or fracture			
20. Trochanteric fracture			
21. ALVAL			

b. For each condition for which you answered Yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)	Treatment Received

VI. MEDICATIONS

FOR ALL QUESTIONS IN THIS SECTION, MEN DO NOT HAVE TO PROVIDE DETAILS AS TO PROSTATE CONDITIONS, AND WOMEN DO NOT HAVE TO PROVIDE INFORMATION AS TO BIRTH CONTROL OR REPRODUCTIVE ISSUES (UNLESS THERE IS A CLAIM RELATED TO CHILD BEARING, AND THEN A FULL OBSTETRICAL AND GYNECOLOGIC HISTORY NEEDS TO BE PROVIDED).

1. List all of the medications (prescription and over the counter) you currently take.

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, are there any prescription medications other than those identified that you have taken on a regular basis for any duration of more than two months for the period five years before your first hip surgery to the present? (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

   Yes _____ No _____

   a. If Yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

VII. IMPLANT/REMOVAL

1. Describe the condition for which the Device was implanted:

_____

_____

_____

a. If this condition the result of an on-the-job injury? Yes ____No ____

If Yes, please state:
Place of employment at the time: _____
Address:_____
Telephone number: _____

Job description/duties at the time: _____
Nature of accident: _____

2. Before the implantation of the Device, did you receive non-surgical treatment for your hip? Yes _____ No _____

   a. State the period during which you received non-surgical treatment:

   _____

   b. State the nature of the non-surgical treatment (*e.g.*, rest, physical therapy, medication, injections): _____

   _____

   c. State the name and address of all doctors or health care providers involved in your non-surgical treatment:

   _____

   _____

   _____

3. Did you see, read or rely upon any documents or other information from DePuy in making your decision to have the Device implanted? Yes ___ No ___

   a. If Yes, identify each document/source of information. _____

   _____

   b. When did you read the document/receive the information? _____

   _____

   c. How did you obtain the document or information? _____

   _____

   d. Do you have the document or written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet. Yes _____ No _____ I don't know _____

   If you no longer have the document or written information in your possession, please describe the information that you received to the best of your ability:

   _____

   _____

4. Were you given any verbal or written instructions, warnings or other information regarding the implantation of the Device? Yes___ No ___ I don't know ___

   a. If Yes, when did you receive the information? _____

   b. Who gave you the information? _____

   c. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet. Yes _____ No _____ I don't know _____

   d. Please describe the oral instructions/warnings you received to the best of your ability:

   _____

   _____

   _____

5. a. When did you learn that the Device had been recalled? _____

_____

b. How did you learn about the recall?_____

_____

c. Did you discuss the recall with any physicians? Yes _____ No _____

If Yes, please identify the physicians, the address, the approximate date(s) of said discussion(s), and the approximate number of times you discussed this with him/her/them:_____

_____

_____

d. Did you contact the Broadspire call center regarding the recall? Yes ___No ___

If Yes, please provide the following information:

i. Did you receive a claim number? Yes ___No ___

If Yes, what is your claim number? _____

ii. Did you receive any expense reimbursement through this process?
Yes___ No___

iii. Do you want to receive copies, at your expense (advanced by your attorney for the fair and ordinary costs of copying), of the medical records that Broadspire obtained about you pursuant to your authorization (if any)?

Yes___ No___

6. Have you had any communications with any present or former employee of DePuy, Johnson & Johnson or any ASR distributor or sales representative concerning the Device or matters in any way related to this lawsuit? Yes _____ No _____

If Yes, for each, please state:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication (In Person, By Phone, By Email, By Mail)	Do you have a writing or recording? (IF SO, PLEASE ATTACH)

If the communication was by phone or in-person, please tell us what was said:

_____
_____
_____

VIII. INJURIES & DAMAGES

1. Are you claiming any physical injuries or illness as a result of the Device?

Yes _____ No _____

If Yes, please describe in detail the following:

a. The physical injuries or illness claimed and when the symptoms began:_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

b. Are those injuries or illnesses continuing? Yes _____ No _____

c. Provide the approximate date of treatment for each condition, and identify the name and address of each health care provider that you have seen for these problems:

Condition You Experienced	Approximate Date of Treatment	Name, Address and Telephone Number of Health Care Provider (if any)

d. Have you ever been hospitalized as a result of any of these conditions?

Yes _____ No _____

If Yes, please provide the following information:

i. Approximate date(s) of hospital admission:_____

ii. Approximate date(s) of discharge:_____

iii. Hospital names(s) and address(es):_____

_____

_____

2. Do you claim any psychological or psychiatric injury (other than garden variety emotional distress) as a consequence of having the Device? Yes _____ No _____

If Yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

3. Are you making a claim for lost wages or lost earning capacity?

Yes _____ No _____

a. If Yes, describe your claim and attach your W-2 forms for the past (5) years. Your description should include the total amount of time (and amount of income) which you have lost or will lose from work as a result of any condition which you claim or believe was caused by the Device, and an explanation of how those amounts were calculated:

_____

_____

_____

_____

b. If you claim a loss of earnings, state your earned income from work for the following years:

YEAR	INCOME
2010	$
2009	$
2008	$
2007	$
2006	$
2005	$

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, which you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition which you claim or believe was caused by the Device for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$
		$

For any expenses claimed above, have they been reimbursed by any third party, including but not limited to Broadspire? Yes _____ No _____

If Yes, identify which expenses, the amount reimbursed and the date reimbursed.

_____

_____

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased?

   Yes _____ No _____

   If Yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration:

   (NOTE: In lieu of the following, please attach a copy of the death certificate)

   Date of death: _____
   Place of death (city, state and country): _____
   _____
   Facility or location where death occurred: _____
   _____
   Name of physician who signed death certificate: _____
   _____
   Cause of death: _____
   _____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed?

   Yes _____ No _____

   If Yes, please attach a copy of the autopsy report.

XI. FACT WITNESSES

Please identify all persons whom you believe possess information concerning you injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address, and relationship to you:

Name:
Address:
Relationship to you:

Name:
Address:
Relationship to you:

Name:
Address:
Relationship to you:

XII. DOCUMENT DEMANDS

These document requests are not intended to seek attorney client communications, or attorney work product materials. In addition, these requests do not encompass or seek information about expert witnesses or communications with and/or from experts or proposed trial exhibits or trial materials which may be subject to disclosure at a later date in accordance with subsequent Court Order or rule. Thus, if you have any of the following in your possession which is not protected as set forth above, please provide a copy of it with this Plaintiff Fact Sheet.

REQUEST NO. 1: All medical records from any physician, hospital or health care provider who has treated you for any injury, illness and/or disease identified in response to this Plaintiff Fact Sheet.

REQUEST NO. 2: All radiographs (x-rays, ultrasounds, MRIs, CT scans) that relate to the condition and injuries alleged in plaintiff's complaint, show any portion of plaintiff's hip and/or depict the Device.

REQUEST NO. 3: All laboratory reports and results of blood tests performed on plaintiff that show the level of cobalt and chromium ion levels in the blood.

REQUEST NO. 4: All medical bills for which plaintiff seeks recovery in this lawsuit, as well as all documents relating to third-party payments of medical bills.

REQUEST NO. 5: All records of any other expenses allegedly incurred as a result of the injuries alleged in the complaint.

REQUEST NO. 6: All photographs and videos of plaintiff's surgery and all photographs and videos of plaintiff which show plaintiff's condition since the date of the original implantation

REQUEST NO. 7: Any documents including but not limited to literature or warnings received by you from surgeons, physicians, or other health care professionals who have treated you for any condition related to the Device.

REQUEST NO. 8: Any documents including diaries, journals, calendars, emails, texts, postings on websites, blogs, and social media accounts (e.g. Facebook, MySpace, or Twitter) or other notes prepared by plaintiff or plaintiff's representative, other than plaintiff's attorneys, concerning DePuy, and plaintiff's physical and emotional health.

REQUEST NO. 9: All materials you received concerning the recall of the Device, whether created by DePuy, your health care provider, or any other third party.

REQUEST NO. 10: Decedent's death certificate, letter of administration, and/or autopsy report (if applicable).

REQUEST NO. 11: All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first hip surgery.

XIII. AUTHORIZATIONS

Complete and sign the attached Authorizations.

XIV. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in part XII of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Date: _____ _____

Signature

EXHIBIT B

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:
Patient Name:
DOB:
SSN:

I, _____, hereby authorize you to release and furnish to: Drinker Biddle & Reath LLP, Tucker Ellis & West LLP, Barnes & Thornburg LLP, Nutter McClennen & Fish LLP, Skadden Arps and/or their duly assigned agents, including Record Trak, copies of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
* 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.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for the purpose of litigation. You are not authorized to discuss 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, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**

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 in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his 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 not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name:_____(plaintiff/representative)

Signature:_____ Date_____