

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

IN RE: EXACTECH POLYETHYLENE ORTHOPEDIC PRODUCTS LIABILITY LITIGATION	)	MDL Docket No. 3044
	)	
	)	THE HON. NICHOLAS G. GARAUFIS, U.S.D.J.
	)	
	)	<u>PLAINTIFF'S PRELIMINARY DISCLOSURE FORM</u>

Instructions: Please provide the following information for each individual on whose behalf a claim is being made relating to implantation of an Exactech Device. When providing names and addresses please provide the full name and full address, including street number, street name, city, state and zip code.

I. CASE INFORMATION			
Caption:		Primary Attorney & Contact Information:	
Docket No.:			
II. PATIENT INFORMATION			
Name of Individual Implanted with Exactech Device:			Date of Birth:
Address:	Street:	Loss of Consortium Claim:	Yes No
	City:		
	State: Zip:		
Last 4 Digits of Social Security No.:	xxx-xx-	If yes, name of spouse:	
Name & Contact Information of Estate Representative if Individual Implanted with Exactech Device is Deceased:			

III. EXACTECH DEVICE IMPLANT INFORMATION #1				
Identify Location of Body Where Product(s) at Issue Was Implanted:	Right hip	Left hip	Both hips	No hip (check one)
	Right knee	Left knee	Both knees	No knee (check one)
	Right ankle	Left ankle	Both ankles	No ankle (check one)
<i>If implanted with more than one Exactech Device, complete Sections III and IV for each Exactech Device. Fill out the information below for each implant and removal surgery. Add additional sheets as needed.</i>				
Right Side Implantation Surgery #1				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

Left Side Implantation Surgery #1				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #1							
	Surgery #1		Surgery #2		Surgery #3		
Date of Revision Surgery(ies):							
Name(s) and Address(es) of Explanting Surgeon(s):	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Name(s) and Address(es) of Medical Facility(ies) Where Revision Surgery(ies) Was Performed:	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Identify the components removed during the revision surgery:							
Are You in Possession of Explanted Component(s)?	Yes No		Yes No		Yes No		
Location of Explant(s):							
Identify Location of Body Where Revision Surgery Was Performed:	Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		

III. EXACTECH DEVICE IMPLANT INFORMATION #2				
Identify Location of Body Where Product(s) at Issue Was Implanted:	Right hip	Left hip	Both hips	No hip (check one)
	Right knee	Left knee	Both knees	No knee (check one)
	Right ankle	Left ankle	Both ankles	No ankle (check one)
<i>If implanted with more than one Exactech Device, complete Sections III and IV for each Exactech Device. Fill out the information below for each implant and removal surgery. Add additional sheets as needed.</i>				
Right Side Implantation Surgery #2				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

Left Side Implantation Surgery #2				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #2							
	Surgery #1		Surgery #2		Surgery #3		
Date of Revision Surgery(ies):							
Name(s) and Address(es) of Explanting Surgeon(s):	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Name(s) and Address(es) of Medical Facility(ies) Where Revision Surgery(ies) Was Performed:	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Identify the components removed during the revision surgery:							
Are You in Possession of Explanted Component(s)?	Yes No		Yes No		Yes No		
Location of Explant(s):							
Identify Location of Body Where Revision Surgery Was Performed:	Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		

III. EXACTECH DEVICE IMPLANT INFORMATION #3				
Identify Location of Body Where Product(s) at Issue Was Implanted:	Right hip	Left hip	Both hips	No hip (check one)
	Right knee	Left knee	Both knees	No knee (check one)
	Right ankle	Left ankle	Both ankles	No ankle (check one)
<i>If implanted with more than one Exactech Device, complete Sections III and IV for each Exactech Device. Fill out the information below for each implant and removal surgery. Add additional sheets as needed.</i>				
Right Side Implantation Surgery #3				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

Left Side Implantation Surgery #3				
Type of Exactech Device: (check one only)	Optetrak Classic	Optetrak Logic	Truliant	Vantage
	Connexion GXL	Conventional UHMWPE Hip Liner		
Expiration Date for the Polyethylene Component if Indicated on Bar Code or Other Medical Records:			Date of Implantation:	
Catalog No./Lot No./Serial No. for Each Exactech Component:				
Name and Address of Implanting Surgeon:		Name: Street: City: State: Zip:		
Name and Address of Medical Facility Where Implant Surgery Performed:		Name: Street: City: State: Zip:		

IV. EXACTECH DEVICE REVISION SURGERY INFORMATION #3							
	Surgery #1		Surgery #2		Surgery #3		
Date of Revision Surgery(ies):							
Name(s) and Address(es) of Explanting Surgeon(s):	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Name(s) and Address(es) of Medical Facility(ies) Where Revision Surgery(ies) Was Performed:	Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		Name: Street: City: State: Zip:		
Identify the components removed during the revision surgery:							
Are You in Possession of Explanted Component(s)?	Yes No		Yes No		Yes No		
Location of Explant(s):							
Identify Location of Body Where Revision Surgery Was Performed:	Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		Right hip Left hip Both hips No hip Right knee Left knee Both knees No knee Right ankle Left ankle Both ankles No ankle		

V. ADDITIONAL MEDICAL INFORMATION

Imaging Study(ies) Conducted? (e.g., MRI/CT/ X-Rays)	Yes No	If yes, list which reports are available:	
Pathology Studies Conducted?	Yes No	If yes, list which reports and/or specimens are available:	

VI. DOCUMENTS TO BE ATTACHED

1. Attach records establishing the product identification and pages with manufacturer/product stickers for every product implanted;
2. Attach the implant operative report(s);
3. Attach the revision operative report(s); and
4. Attach the revision pathology report(s).

BY: _____ *Dated:* _____

Attorney for Plaintiff: