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. **PLAINTIFF'S PRELIMINARY DISCLOSURE FORM**

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: City: State: Zip:	Loss of Consortium Claim:	Yes ☐ No ☐
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)

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.

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)

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.

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)

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.

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: