UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
SOUTH BEND DIVISION

IN RE: BIOMET M2a MAGNUM HIP IMPLANT PRODUCT LIABILITY LITIGATION **(MDL 2391)** **This Document Relates to All Cases**	)))))))	**Cause No. 3:12-MD-2391-RLM-CAN** **Judge Robert L. Miller, Jr.**

It is hereby ordered that any Plaintiff with a case pending in the above referenced litigation shall complete and serve a Preliminary Disclosure Form, attached as Exhibit A to this Order, within thirty (30) days of the entry of this Order. Service shall be made on Defendants' liaison counsel, Ryan C. Edwards, Taft Stettinius & Hollister LLP, by sending the form electronically by email to BiometPFS@taftlaw.com and a curtsey copy should be served on Plaintiffs' liaison counsel, Douglas A. Kreis, Aylstock, Witkin, Kreis & Overholtz, PLLC, by sending it electronically by email to BiometPDF@awkolaw.com.

For all cases filed after the date of this Order, the Preliminary Disclosure Form is to be served thirty (30) days from the date that the case is transferred into the MDL, or, if directly filed in the MDL, thirty (30) days from the date that the case is filed.

This Preliminary Disclosure Form must be completed and served regardless of whether a Plaintiff has previously served 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.

IT IS SO ORDERED.

ENTERED: January 7, 2014

____/s/ Robert L. Miller, Jr._____
Robert L. Miller, Jr.
Judge, United States District Court

Exhibit A

BIOMET PRELIMINARY DISCLOSURE FORM
DO NOT FILE THIS FORM WITH THE COURT

1. Plaintiff Information

(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) Date Filed: _____
(Please format as MM/DD/YYYY)

(f) Attorney: _____

2. Implant Information

(a) Location of Implant: Right ☐ Left ☐ Bilateral ☐

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

i. Hospital: _____

ii. Surgeon: _____

(c) Implant date (Left): _____
(Please format as MM/DD/YYYY)

i. Hospital: _____

ii. Surgeon: _____

3. **Revision Information:**

(a) Location of revision: Right ☐ Left ☐ Bilateral ☐

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

i. Hospital: _____

ii. Surgeon: _____

(c) Revision date (Left): _____
(Please format as MM/DD/YYYY)

i. Hospital: _____

ii. Surgeon: _____

(d) If you have not had a revision yet, but one is scheduled, provide the date: _____
(MM/DD/YYYY)

(e) 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 ☐

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

Date(s) of Discussion (MM/DD/YYY): _____

Doctor: _____

Address: _____

Medical condition: _____

_____

_____

_____

4. Post-Revision Surgery

Do you claim that your revision surgery led to any of the following: Yes ☐ No ☐

	DATE (MM/DD/YYYY)
(a) A second revision	_____
(b) A third revision	_____
(c) A forth revision	_____
(d) Death	_____
(e) Heart attack	_____
(f) Stroke	_____
(g) Pulmonary embolism	_____
(h) Deep vein thrombosis/blood clot	_____
(i) Fracture (femoral shaft or Trochanteric)	_____

(j) Dislocation(s): Yes ☐ No ☐ Number of dislocations: _____

Please provide the DATE(S) of any dislocations (MM/DD/YYYY): _____

(k) Infection(s): Yes ☐ No ☐

Please provide the DATE(S) of any infections (MM/DD/YYYY): _____

If you marked yes for infection, please check the box for any and all of the following treatment received:

IV antibiotic treatment ☐ Antibiotic spacers ☐ Irrigation & Debridement ☐

(l) Permanent and full time use of a wheel chair or walker for ambulation (not used prior to revision surgery): Yes ☐ No ☐

(m) Foot drop: Yes ☐ No ☐

Note: Only mark yes if this is documented in the medical records after revision surgery.

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

_____

_____

(n) Peripheral neuropathies or nerve damage (with objective EMG evidence): Yes ☐ No ☐
DATE: _____
(MM/DD/YYYY)

(o) Other Extreme Conditions/loss: Yes ☐ No ☐

Explain:_____

_____

5. Other Surger(ies)

Have you had any other surgery post-revision (not already identified above) that you claim is related to the implant? Only answer yes if you have undergone surgery. Do not answer yes if you have only received injections. Yes ☐ No ☐

Please state the condition treated:_____

_____

_____

_____

Please provide the DATE(S) of any additional surgery(ies) (MM/DD/YYYY):_____

_____

_____

To the extent that 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 Question 4 above.