UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

IN RE: PROPULSID PRODUCTS LIABILITY LITIGATION	:	**MDL NO. 1355**
	:	**SECTION: L**
	:	**JUDGE FALLON**
	:	**MAG. JUDGE AFRICK**
THIS DOCUMENT RELATES TO ALL CASES	:	

PRETRIAL ORDER NO. 9
(Plaintiff Profile Form/Execution of Authorizations)

Upon the Joint Motion of the Plaintiffs' Steering Committee ("PSC") and Defendants' Liaison Counsel ("DLC") that the plaintiffs in MDL 1355 shall prepare answers to the Patient Profile Form and execute verified Authorizations (hereinafter "PPF"), thereby providing defendants access to medical and related records, as set forth in the PPF.

IT IS HEREBY ORDERED THAT:

1. As to all cases that are transferred by Order of this Court in MDL 1355 as of January 29, 2001, the PPFs in the form attached shall be answered and the verified authorizations in the form attached shall be provided to the DLC within forty-five (45) days or by March 15, 2001.

2. Plaintiffs whose cases have been transferred after the PPF has been approved and put on-line shall provide completed PPFs and verified authorizations to the DLC within forty-five (45) days of their transfer order.

3. This order shall be posted on the Court's website for MDL 1355 located at **http://propulsid.laed.uscourts.gov.** Counsel unable to access the Court's website for MDL 1355 may contact the Clerk of Court for information on obtaining a copy of this order.

4. If plaintiff indicates in the PPF that he or she is making a wage loss claim, then the defendants may use authorizations to obtain employment records and income tax returns for six years preceding the date of the authorization. In all cases where a wage loss claim is not made, defendants assert their right to obtain discovery of plaintiffs' employment records and will work amicably with plaintiffs' counsel to resolve this issue.

5. Plaintiffs shall identify psychiatric or psychological healthcare providers and all psychotropic medications in the PPF.

6. In all cases asserting any claim for mental and/or emotional damages plaintiff must either provide an authorization for psychiatric and psychological records or dismiss such claims, within 15 days of defendants' request for such authorization. In the event a plaintiff has seen a psychiatrist and chooses to dismiss his or her claim for mental or emotional damages, plaintiff will provide an authorization entitling defendants to receive from the psychiatrist a list of all medications prescribed and the dates thereof for the period of time the plaintiff was taking Propulsid.

7. In the event psychiatric or psychological records are inadvertently obtained or provided by a healthcare provider without proper authorizations, defendants shall return the original

records to counsel for the plaintiff, without retaining any copies and without any prejudice to any parties' further rights. The inadvertent production shall not waive or destroy any rights or privileges of plaintiffs.

8. Upon receipt of medical records, defendants shall immediately mark them as confidential and maintain the confidentiality of such records throughout the pendency of the litigation. Upon the conclusion of the litigation, all medical records shall be returned to the plaintiff and no copies shall be retained.

9. Defendants will notify plaintiffs' counsel upon receipt of any medical records and upon request by plaintiff's counsel, copies shall be provided to plaintiff at plaintiff's reasonable costs.

10. Defendants' use of the PPFs and executed authorizations shall be without prejudice to any defendant's right to serve additional non-duplicative discovery. Plaintiffs reserve the option to object to any such discovery under Fed. Rule Civ. Proc. 26(c).

New Orleans, Louisiana, this 31 day of January, 2001.

JUDGE ELDON E. FALLON
UNITED STATES DISTRICT JUDGE

IN RE: PROPULSID® LITIGATION

THIS RELATES TO:

Civil Action No:

[plaintiff's name]

v.

[defendants' names]

MDL Docket No. 1355

PATIENT PROFILE FORM

Please provide to the best of your knowledge the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who used Propulsid. Those questions using the term "You" refer to the person who used Propulsid. In filling out this form, please use the following definitions: (1) "health care - provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advice, and any pharmacy, weight loss center, counselor, dentist, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phono-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions.

If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name

2. Address _____

3. In what capacity you are representing the individual _____

4. If you were appointed by a court, state the court & date of appointment_____

5. Your relationship to deceased or represented person_____

6. If you represent a decedent's estate, state the date of death of decedent_____

I. Personal Data

a. Name: _____

b. Any other names used and dates of use:_____

c. Address: _____

d. Date when began living at current address: _____

e. All prior addresses during last ten years and corresponding dates:

f. Social Security Number: _____

g. Date and place of birth: _____

h. Date of Death, if applicable: _____

i. Marital Status: _____

j. Name(s) of current and former spouse(s) and date(s) of marriage(s), if applicable:

k. Name(s) and date(s) of birth of children, if applicable:

l. Current employer
- (i) Name: _____
- (ii) Address: _____
- (iii) Duties: _____
- (iv) Job title: _____
- (v) Dates Employed: _____
- (vi) Full-time or Part-time: _____
- (vii) Are you making a wage loss claim? _____ Yes _____ No
  If "yes," state your annual income:
- (viii) Did you leave the job for a medical reason? _____ Yes _____ No
  If "yes," describe why you left that job:
- (ix) Name of Supervisor: _____

m. All employers (other than current employer) that you have had in the last ten years:

- (i) Name: _____
- (ii) Address: _____
- (iii) Duties: _____
- (iv) Job title: _____
- (v) Dates Employed: _____
- (vi) Full-time or Part-time: _____
- (vii) Are you making a wage loss claim? _____ Yes _____ No
  If "yes," state your annual income:
- (viii) Did you leave the job for a medical reason? _____ Yes _____ No
  If "yes," describe why you left that job:
- (ix) Name of Supervisor: _____

n. Schools you have attended (high school and beyond only):

(i) High School
- (a) Name:
- (b) Address:
- (c) Grade completed:
- (d) Year graduated:

(ii) Did you attend school beyond high school? _____ Yes _____ No

If "yes," then as to each school separately state:
(a) Name:
(b) Address:
(c) Dates of attendance:
(d) Degree awarded:
(e) Major or primary field

o. Has any insurance or other company provided medical coverage to you or paid medical bills on your behalf at any time beginning ten years prior to prescription of Propulsid® to the present? _____ Yes _____ No

If "yes," then as to each Company, separately state:
(i) Name of company:
(ii) Address of company:
(iii) When company made payments:
(iv) Medical conditions for which payments were made:

p. Have you ever applied for worker's compensation social security or state or federal disability benefits?

If "Yes," then as to each application, separately state:
(i) Date (or year) of application:
(ii) Type of benefits:
(iii) Amount awarded:
(iv) Basis of your claim:
(v) If denied, reason for denial:
(vi) To what agency or company did you submit your application (e.g. Maryland Division of Social Security):

q. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?_____

If yes, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action, or suit.

II. Health Care Providers

a. For each healthcare provider whom you have seen during the last fifteen (15) years, state:

(i) Name: ______________________________
(ii) Specialty, if any: ______________________________
(iii) Address: ______________________________
(iv) Phone: ______________________________
(v) Reason(s) for Visit(s): ______________________________

(vi) Medications prescribed or recommended by provider: ______________________________

(i) Name: ______________________________
(ii) Specialty, if any: ______________________________
(iii) Address: ______________________________
(iv) Phone: ______________________________
(v) Reason(s) for Visit(s): ______________________________

(vi) Medications prescribed or recommended by provider: ______________________________

(i) Name: ______________________________
(ii) Specialty, if any: ______________________________
(iii) Address: ______________________________
(iv) Phone: ______________________________
(v) Reason(s) for Visit(s): ______________________________

(vi) Medications prescribed or recommended by provider: ______________________________

(i) Name: ______________________________
(ii) Specialty, if any: ______________________________
(iii) Address: ______________________________
(iv) Phone: ______________________________
(v) Reason(s) for Visit(s): ______________________________

(vi) Medications prescribed or recommended by provider: ______________________________

(i) Name: _____
(ii) Specialty, if any:_____
(iii) Address: _____
(iv) Phone: _____
(v) Reason(s) for Visit(s): _____

(vi) Medications prescribed or recommended by provider: _____

*Please attach additional pages if necessary

b. For each hospitalization that you have undergone in the last fifteen (15) years, state:
(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____

(i) Name: _____
(ii) Address:_____
(iii) Phone:_____
(iv) Reason(s) for Hospitalization(s):_____

*Please attach additional pages if necessary.

c. For each surgery you have undergone in the last fifteen (15) years, state:

(i) Name of operation:_____
(ii) Name of surgeon_____
(iii) Address of surgeon_____
(iv) Reason for surgery_____

d. Have you ever consulted a physician or a clinic facility regarding any gastrointestinal condition or disease including but not limited to heartburn, ulcers, gastroenteritis, bleeding, pain? If yes, state:

(i) Name of doctor or facility_____
(ii) Address_____
(iii) Date_____
(iv) Diagnosis_____
(v) Treatment_____
(vi) Medications_____
(vii) Did condition resolve?_____
(viii) Current status of condition_____

e. Have you ever had any of the following tests to evaluate for cardiac/heart disease or abnormality:

(i) Electrocardiogram [EKG/ECG]_____
(ii) Cardiac Catheterization_____
(iii) Exercise Stress Test_____
(iv) Holter Monitor_____
(v) Thallium Scan_____
(vi) Echocardiogram_____
(vii) Other diagnostic test of heart, lungs or cardiopulmonary blood vessels

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If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

f. Have you to the best of your knowledge ever had any of the following tests to evaluate for gastrointestinal disease or abnormality:

(i) Upper GI Series_____
(ii) Barium Swallow_____
(iii) Esophagram_____
(iv) Small bowel x-ray_____
(v) Esophagoscopy_____
(vi) Endoscopy_____
(vii) Gastroscopy_____
(viii) Colonoscopy_____
(ix) Other diagnostic test or imaging of the gastrointestinal tract_____

If yes, please state separately for each:

(i) Type of test_____
(ii) Date administered_____
(iii) Reason for test_____
(iv) Facility name and address_____
(v) Ordering doctor_____
(vi) Results/diagnosis_____
(vii) Treatment_____

III. Medical Background

a. Height:_____

b. Weight_____

c. Smoking History

1. never smoked cigarettes_____

2. past smoker of cigarettes_____
date on which smoking ceased_____
Amount smoked: _____ packs per day for _____ years

3. current smoker of cigarettes
Amount smoked: _____ packs per day for _____ years

IV. Propulsid®

a. Have you ever taken Propulsid®? _____ Yes _____No

b. If "yes," then separately state or identify:
(i) dosage(s):
(ii) date(s) of use:
(iii) the healthcare provider(s), who prescribed Propulsid® to you:
(iv) describe separately for each medication you have identified in 3b(i):
(v) person(s) or source from which you obtained Propulsid®
(vi) reason you understood you were prescribed Propulsid®

c. Did you receive any written or oral information about Propulsid® before you took it?
_____ Yes _____ No

d. Did you receive any written or oral information about Propulsid® while you took it?
_____ Yes _____ No

If you responded "yes" to 3c and/or 3d, separately state or describe:

(i) when you received that information;
(ii) from whom you received it;
(iii) what information you received;

e. Did you receive any written information regarding Propulsid®?

_____ Yes _____ No

If yes, please attach all such documentation in your possession.

V. Injuries, Symptoms, Diagnoses, Ailments & Damages

a. Are you claiming that you have or may develop any physical condition as a result of taking Propulsid®?

_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?

_____ Yes _____ No

If "yes" to subpart (v) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?

_____Yes_____No

b. Has any healthcare provider told you, orally or in writing, that any of these conditions are due to your use of any of Propulsid®?

_____Yes _____ No

If "yes," then state and describe:
(i) what you were told;
(ii) who told you and when;

c. Are you claiming that you have paid or will have to pay any expenses as a result of having taken Propulsid®?

_____Yes _____No

If "yes," then for each item separately identify:
(i) for what;
(ii) amount of fees or expenses:
(iii) person or company paid or to be paid.

d. Other than those previously identified, are you claiming that you have suffered any other injuries or damages (including any alleged mental, emotional, psychological or psychiatric injuries or damages) as a result of taking Propulsid®?
_____ Yes _____ No

If "yes," then for each such condition, separately state:
(i) Nature of condition;
(ii) The date you first became aware of it;
(iii) How you first became aware of it;
(iv) Whether (and if so, how) it has changed over time;
(v) For each such condition, have you consulted with healthcare provider(s)?
_____ Yes _____ No

If "yes" to subpart (d) then, as to each healthcare provider, state:
(A) the healthcare provider's name;
(B) the healthcare provider's address;
(C) the date of first consultation with that healthcare provider;
(D) date of last consultation;
(E) do you plan to continue to consult with that healthcare provider?
_____Yes_____No

VI. Other Medications, Supplements, Or Drugs

Indicate to the best of your knowledge whether you ever took the medication during a time when you were taking Propulsid. If yes, please indicate dates taken and prescribing doctor under comments section.

	YES	NO	IF YES, DATES TAKEN, PRESCRIBING DOCTOR	NAME AND ADDRESS OF PHARMACY WHERE OBTAINED
ANTI-INFECTIVE DRUGS:				
Biaxin [Clarithromycin]	____	____		
Cipro [Ciprofloxaxin]	____	____		
Crixivan [Indinavir]	____	____		
Diflucan [Fluconazole]	____	____		
Erythrocin & others [Erythromycin]	____	____		
Flagyl [Metronidazole]	____	____		
Keflex [Cephalexin]	____	____		
Nizoral [Ketoconazole]	____	____		
Norvir [Ritonavir]	____	____		

Sporanox [Itraconazole]	____	____
TAO [Troleandomycin]	____	____
Zagam [Sparfloxacin]	____	____
ANTIDEPRESSANTS:		
Adapin, Sinequan [Doxepin]	____	____
Elavil [Amitriptylene]	____	____
Lithobid, Eskalith [Lithium]	____	____
Ludiomil [Maprotilene]	____	____
Norpramin [Desipramine]	____	____
Pamelor [Nortriptylene]	____	____
Prozac [Fluoxetine]	____	____
Remeron [Mirtazapine]	____	____
Serzone [Nefazadone]	____	____
Tofranil [Imipramine]	____	____
CARDIOVASCULAR DRUGS:		
Adalat [Nifedipine]	____	____
Betapace [Sotalol]	____	____
Cardiazem [Diltiazem]	____	____
Cordarone [Amiodarone]	____	____
Dyazide [HCTZ/Triamterene]	____	____
Hydrodiuril [Hydrochlorothiazide]	____	____
Inderal [Propranalol]	____	____
Lanoxin [Digoxin]	____	____
Lasix [Furosemide]	____	____
Norpace [Disopyramide]	____	____
Pronestyl [Procainamide]	____	____
Quinidex [Quinidine]	____	____
Tenormin [Atenolol]	____	____
Vascor [Bepridil]	____	____
CENTRAL NERVOUS SYSTEM DEPRESSANTS:		
Compazine [Prochlorperazine]	____	____
Haldol [Haloperidol]	____	____
Mellaril [Thioridazine]	____	____
Serdolect [Sertindole]	____	____
Thorazine [Chlorpromazine]	____	____
Triavil, Trilfon [Perphenazine]	____	____
OTHER:		
Hismanal [Astemizole]	____	____
Luvox [Fluvoxamine]	____	____
Mevacor [Lovastatin]	____	____
Terodilene	____	____

VII. Family History

1. To the best of your knowledge did any child, parent, sibling, aunt, uncle, or grandparent of yours suffer from any type of heart disease including but not limited to: abnormal rhythm, arteriosclerosis (hardening of the arteries), murmur,

coronary artery disease, congestive heart failure, enlarged heart, leaking valves or prolapse, heart block, congenital heart abnormality, Scarlet Fever, Rheumatic Fever, atrial fibrillation?
yes_____ no_____

2. If yes, then state separately for each:
relative's name_____
relationship to you_____
type of heart problem_____
date and cause of death if applicable_____

3. For infants and young children: was Propulsid® used during a period of time while the child was being breastfed? Yes ____ No ___ . If yes, please answer questions II and VI for the nursing mother limited to the period of time that the child was both breast fed and taking Propulsid®.

VIII. Authorizations

Complete and sign the attached Authorization for Release of Hospital, Medical and Pharmacy Records. If you are making a wage loss claim, then sign the attached Authorization for release of employment records.

I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respects incomplete or incorrect.

I verify under oath that the above responses are true and correct to the best of my knowledge.

Date:

Signature

AUTHORIZATION FOR RELEASE OF HOSPITAL, MEDICAL AND PHARMACY RECORDS

Plaintiff/Patient's Name: _____

Date of Birth: _____ Social Security No. _____

Plaintiff/Patient's Current Address(es) _____

TO:

You are hereby authorized to disclose, make available and furnish to: James B. Irwin of the law firm of Irwin Fritchie Urquhart & Moore; Charles F. Preuss of the law firm of Preuss, Shanagher, Zvloff & Zimmer; and/or Thomas F. Campion of Drinker Biddle & Shanley, attorneys for Defendants Johnson & Johnson, Janssen Pharmaceutica Inc. and Janssen Pharmaceutic Research Foundation, copies of all records regarding my medical condition and treatment including but not limited to all information relating to AIDS and HIV status. This information includes but is not limited to medical records, copies of films (x-ray, photographs, photographic slides or otherwise) pathology slides, diagnostic reports and laboratory testing reports. No originals will be released. No pathology material will be released.

This authorization does not apply to psychiatric or psychological records. Psychological and/or psychiatric records cannot be released without a specific signed authorization requesting these records. References to psychotropic medications should not be redacted.

This will further authorize you to provide updated medical records for the undersigned to the above law firms and corporations until two (2) years from the date below. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Dated: ____ day of _____, 2001.

Signature of Plaintiff

Print or Type Name

Sworn to and subscribed before me this
____ day of _____, 2001.

My lawyer's name, address and telephone number are: _____

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

Plaintiff/Patient's Name: _____

Date of Birth: _____ Social Security No. _____

Plaintiff/Patient's Current Address(es) _____

TO:

You are hereby authorized to disclose, make available and furnish to: James B. Irwin of the law firm of Irwin Fritchie Urquhart & Moore; Charles F. Preuss of the law firm of Preuss, Shanagher, Zvloff & Zimmer; and/or Thomas F. Campion of Drinker Biddle & Shanley, attorneys for Defendants Johnson & Johnson, Janssen Pharmaceutica Inc. and Janssen Pharmaceutic Research Foundation, copies of all records regarding my medical condition and treatment including but not limited to all information relating to AIDS and HIV status. This information includes but is not limited to medical records, copies of films (x-ray, photographs, photographic slides or otherwise) pathology slides, diagnostic reports and laboratory testing reports. No originals will be released. No pathology material will be released.

You are authorized to release any psychiatric, psychological or other confidential records relating to any emotional, substance abuse (including drug and alcohol information) or other psychiatric/psychological condition.

This will further authorize you to provide updated medical records for the undersigned to the above law firms and corporations until two (2) years from the date below. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Dated: ____ day of _____, 2001.

Signature of Plaintiff

Print or Type Name

Sworn to and subscribed before me this
____ day of _____, 2001.

My lawyer's name, address and telephone number are: _____

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

Plaintiff/Employee's Name: _____

Date of Birth: _____ Social Security No. _____

Plaintiff/Employee's Current Address(es) _____

TO:

You are hereby authorized to disclose, make available and furnish to: James B. Irwin of the law firm of Irwin Fritchie Urquhart & Moore; Charles F. Preuss of the law firm of Preuss, Shanagher, Zvloff & Zimmer; and/or Thomas F. Campion of Drinker Biddle & Shanley, attorneys for Defendants Johnson & Johnson, Janssen Pharmaceutica Inc. and Janssen Pharmaceutic Research Foundation, all records regarding my employment, including confidential personnel files for six years preceding the date of this authorization.

This will further authorize you to provide updated employment records for the undersigned to the above law firms and corporations until two (2) years from the date below. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Dated: ____ day of _____, 2001.

Signature of Plaintiff

Print or Type Name

Sworn to and subscribed before me this
____ day of _____, 2001.

My lawyer's name, address and telephone number are: _____

General Information

Court	United States District Court for the Eastern District of Louisiana; United States District Court for the Eastern District of Louisiana
Federal Nature of Suit	Personal Injury - Product Liability[365]
Docket Number	2:00-md-01355
Status	CLOSED