

UNITED STATES DISTRICT COURT  
 NORTHERN DISTRICT OF INDIANA  
 SOUTH BEND DIVISION

<b>IN RE: BIOMET M2a MAGNUM                  HIP IMPLANT PRODUCT                  LIABILITY LITIGATION</b> (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](mailto: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](mailto: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: \_\_\_\_\_



**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 fourth 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:

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(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.**