**UNITED STATES DISTRICT COURT**

**FOR THE DISTRICT OF MASSACHUSETTS**

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| --- | --- |
| **IN RE: COVIDIEN HERNIA MESH PRODUCTS LIABILITY LITIGATION NO. II,**  **This Document Relates To:**  **PLAINTIFF NAME** | **MDL No. 1:22-md-03029-PBS**  **Civil Action No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**PLAINTIFF PROFILE FORM**

In completing this Plaintiff Profile Form, you must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. As used in this Plaintiff Profile Form, “Covidien Hernia Mesh Device” refers to the medical device or devices about which you are making a claim.

**I. CASE INFORMATION**

**Caption:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Docket No.: \_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Attorney Contact (name, address, phone, and email):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**II. PLAINTIFF INFORMATION**

**Name of Individual Implanted with Covidien Hernia Mesh Device:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**Gender of Individual Implanted with Covidien Hernia Mesh Device: ❑ Male ❑ Female**

**Date of birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last 4 Digits of Social Security No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Loss of Consortium Claim? ❑ Yes ❑ No**

**If yes, name of spouse:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Estate Representative if Individual Implanted with Covidien Hernia Mesh Device is Deceased:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. COVIDIEN HERNIA MESH DEVICE NO. 1**

**Date of Implant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason Covidien Hernia Mesh Device was Implanted (including whether inguinal, femoral, ventral, umbilical, or other type of hernia)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covidien Hernia Mesh Device**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Implanting Surgeon (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Attach the implant operative report and any medical evidence of product identification (product ID sticker).\*\****

**Was the Covidien Hernia Mesh Device Revised or Removed?**

**❑ Yes ❑ No ❑ Partially ❑ Unknown**

**Date of revision/removal surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of revision/removal surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explanting Surgeon (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Facility (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Attach the operative report, any pathology report, and any medical evidence identifying the device removed/revised.\*\****

**A. Plaintiff asserts the following injuries as a result of the Covidien Hernia Mesh Device:**

Abscess(es)  Loss of testicle(s)

Adhesions  Mesh migration

Bowel/intestinal obstruction(s)  Mesh shrinkage

Bowel/intestinal perforation(s)  Nerve damage

Bowel/intestinal removal(s)  Other organ perforation(s)

Death  Pain & Suffering

Recurrence  Seroma(s)

Fistulae  Other (describe below)

Infection(s)

\_\_\_\_\_

Please describe any additional information regarding Plaintiff’s physical injury(ies) that Plaintiff believes were caused as result of the Covidien Hernia Mesh Device: \_ \_ \_ \_ \_ \_ \_ \_

**B. Please list all doctors or other healthcare providers Plaintiff has seen for treatment of any of the alleged injuries listed above.**

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| --- | --- | --- |
| **Provider Name, Address, and Specialty** | **Condition Treated** | **Approximate Dates o**f  **Treatment** |
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**\*\**Attach additional pages as needed to describe injuries or identify other responsive health care providers*.\*\***

**IV. COVIDIEN HERNIA MESH DEVICE NO. 2**

**Date of Implant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason Covidien Hernia Mesh Device was Implanted (including whether inguinal, femoral, ventral, umbilical, or ther type of hernia**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covidien Hernia Mesh Device**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Implanting Surgeon (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Attach the implant operative report and any medical evidence of product identification (product ID sticker).\*\****

**Was the Covidien Hernia Mesh Device Revised or Removed?**

**❑ Yes ❑ No ❑ Partially ❑ Unknown**

**Date of revision/removal surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of revision/removal surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Explanting surgeon (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Facility (name and address)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*Attach the operative report, any pathology report, and any medical evidence identifying the device removed/revised.\*\****

**A. Plaintiff asserts the following injuries as a result of the Covidien Hernia Mesh Device:**

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Bowel/intestinal obstruction(s)  Mesh shrinkage

Bowel/intestinal perforation(s)  Nerve damage

Bowel/intestinal removal(s)  Other organ perforation(s)

Death  Pain & Suffering

Recurrence  Seroma(s)

Fistulae  Other (describe below)

Infection(s)

\_\_\_\_\_

Please describe any additional information regarding Plaintiff’s physical injury(ies) that Plaintiff believes were caused as result of the Covidien Hernia Mesh Device: \_ \_ \_ \_ \_ \_ \_ \_

**B. Please list all doctors or other healthcare providers Plaintiff has seen for treatment of any of the alleged injuries listed above.**

|  |  |  |
| --- | --- | --- |
| **Provider Name, Address, and Specialty** | **Condition Treated** | **Approximate Dates o**f  **Treatment** |
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***\*\*Attach additional pages as needed to describe injuries or identify other responsive health care providers.\*\****

**If more than 2 Covidien Hernia Mesh Devices were implanted, attach additional pages with information above for each additional Covidien Hernia Mesh.**

**V. MEDICAL HISTORY**

1. **Has Plaintiff ever been diagnosed with:**

Diabetes:  **Yes**  **No**  **Unknown/Unsure**

Adhesions or Adhesive Disease:  **Yes**  **No**  **Unknown/Unsure**

Cancer:  **Yes**  **No**  **Unknown/Unsure**

Cardiovascular condition:  **Yes**  **No**  **Unknown/Unsure**

Chronic pain condition:  **Yes**  **No**  **Unknown/Unsure**

Irritable Bowel Syndrome:  **Yes**  **No**  **Unknown/Unsure**

Lupus:  **Yes**  **No**  **Unknown/Unsure**

Auto Immune Disorder:  **Yes**  **No**  **Unknown/Unsure**

Anemia or other blood disorder:  **Yes**  **No**  **Unknown/Unsure**

Respiratory disease (i.e. Emphysema and/or COPD):  **Yes**  **No**  **Unknown/Unsure**

Any disease of the gut, intestines, or bowels:  **Yes**  **No**  **Unknown/Unsure**

**With regard to cigarettes, Plaintiff is a:**

(PLEASE CHECK ONLY ONE)

Non-smoker

Current Smoker (please answer question 1 below)

1. How many packs a day does Plaintiff smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former Smoker (please answer question 2 below)

2. Approximately when did Plaintiff quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe all surgical procedures Plaintiff has undergone in the abdominal, pelvic or inguinal area:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has Plaintiff ever been implanted with another manufacturers’ hernia mesh device?**

**Yes**  **No If Yes, identify device name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VII. OTHER**

A. (1) Is Plaintiff claiming damages for lost wages:  **Yes**  **No**

(2) If so, for what time period(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. (1) In the past seven years has Plaintiff filed for bankruptcy:  **Yes**  **No**

(2) If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATIONS AND MEDICAL RECORDS TO BE PRODUCED**

Provide duly executed medical records authorization forms attached as Ex. A for all healthcare providers identified in Section III.B and IV.B. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

Provide a copy of all medical records in your possession, custody, or control (including any medical records in your attorney’s possession) related to the claims and/or alleged injuries in this case.

Signed this\_\_\_\_Day of\_\_\_\_\_\_\_\_\_, 202\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plaintiff’s Counsel of Record

Firm Name

Firm Address

Firm Address 2

Phone

Email