ROSENBERG LAW

Murphy Battista

# Allergan Adjustable Gastric-Band Class Action

## *Potential Class Member Questionnaire*

Rosenberg Law and Murphy Battista LLP are working together on a proposed class proceeding on behalf of Canadians harmed as a result of the implantation of the Allergan adjustable gastric-band.

As part of the process, the legal team is gathering and collating information regarding the experiences of potential class members. We are also building a database to keep affected individuals informed about the progress of this case.

Potential class member information is confidential but may be shared between the two firms.

Please note that responses to questions and updates about this proposed class proceeding may come from an email address from either law firm.

Please provide your preferred contact details and fill in the information requested below as best you can and email the form to allergan@murphybattista.com with the subject line **Allergan Adjustable Gastric-Band Class Action** and our intake team will be in touch to confirm receipt and next steps.

## Client Identification

| Last Name: | First Name: |
|---|---|
| | |
| **Middle Initial:** | **Date of Birth:** |
| | |
| **Address:** | |
| **Home Phone:** | **Cell Phone:** |
| | |
| **Email Address:** | |

Alternate Contact:

(if we cannot reach you, please provide the name, phone number, and address of an emergency contact we can leave a message with)

Health Card Number: _____

# Gastric-Band Information

Date of the original gastric-band implant: _____

Do you know the brand name or type of gastric-band? ☐ Yes ☐ No

If yes, please provide the brand name information: _____

## Please provide the information of the physician who implanted the original gastric-band below:

| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
|---|---|
| | |
| Hospital/Facility Name: | Hospital Facility Telephone Number: |
| | |
| Hospital/Facility Address: | |

Did you receive one or more gastric-band repair or adjustment(s)? ☐ Yes ☐ No

If more than one, how many? _____

## For each gastric-band repair or adjustment, please provide further details below:

| Date of Repair or Adjustment: | |
|---|---|
| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
| | |
| Hospital/Facility Address: | |

| Date of Repair or Adjustment: | |
|---|---|
| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
| | |
| Hospital/Facility Address: | |

| Date of Repair or Adjustment: | |
|---|---|
| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
| | |
| Hospital/Facility Address: | |

If you have already collected your medical records, in your surgical report there should be a medical device implant sticker. If you have one of these stickers, please take a scan or picture of it and send it in with this questionnaire. Please write the brand name of the gastric band and code on the sticker in this box below:

_____

Please use the space below to provide any further gastric-band repair, adjustment, or removal information:

Did you have the gastric-band removed? ☐ Yes ☐ No

If yes, please provide the details below:

| | |
|---|---|
| Date of Removal: | |
| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
| | |
| Hospital/Facility Name: | Hospital/Facility Telephone Number: |
| | |
| Hospital/Facility Address: | |

Please provide reason(s) for removal:

Were you informed by a medical professional that a revision or removal of the gastric-band would be necessary?
☐ Yes ☐ No

*If yes, please provide the name of the medical professional and the date you were informed:*
(please include details where applicable)

Did you lose weight after the gastric-band was implanted? How much weight? Did you regain weight after the gastric-band was removed? Please Explain:

## Injuries/Symptoms Related to Band

What injuries/symptoms were diagnosed/experienced after the implantation of gastric-band?

(Please select all that apply)

- ☐ Pain
- ☐ Severe pain
- ☐ Acid reflux
- ☐ Acid stomach
- ☐ Vomiting
- ☐ Headaches
- ☐ Nausea
- ☐ Difficulty swallowing
- ☐ Difficulty eating
- ☐ Malnutrition
- ☐ Stomach ulcers
- ☐ Infection
- ☐ Palpitations
- ☐ Dizziness
- ☐ Low blood sugar
- ☐ Tremors
- ☐ Heartburn
- ☐ Damage to stomach
- ☐ Damage to other organs
- ☐ Migraines
- ☐ Hernia
- ☐ Stomach obstruction
- ☐ Blood clot
- ☐ Sepsis
- ☐ Band erosion
- ☐ Band slippage
- ☐ Gallstones
- ☐ Bowel obstruction
- ☐ Diarrhea
- ☐ Hair loss
- ☐ Mental health/distress
- ☐ Hyperglycemia
- ☐ Dumping syndrome
- ☐ Vitamin deficiency
- ☐ Endocrine issues
- ☐ Irritable Bowel Syndrome
- ☐ Bleeding
- ☐ Scar tissue
- ☐ Kidney stones
- ☐ Other (please specify below):

Please provide detail of your injuries:

Please provide the approximate date when the symptoms or complications from the gastric-band began:

Were you advised that the band was for long-term use? What did you understand this to mean?

**Please provide the details of the physician who treated you or you visited relating to any side effects of the band:**

| Physician's Name (First Name, Last Name): | Physician's Telephone Number: |
|---|---|
| | |
| Hospital/Facility Name: | |

Any further details/comments regarding your injuries/symptoms related to band:

## Other Physician Information

Did you receive treatment and/or consultation with any other healthcare provider, physician, or specialist? (i.e. massage therapists, private clinics, etc.) ☐ Yes ☐ No

If yes, please provide us additional information in the section below:

| Healthcare Provider | |
|---|---|
| Type of Treatment: | Date(s): |
| | |
| Name (First Name, Last Name): | Telephone Number: |
| | |
| Address: | |

| Healthcare Provider | |
|---|---|
| Type of Treatment: | Date(s): |
| | |
| Name (First Name, Last Name): | Telephone Number: |
| | |
| Address: | |

# Financial & Employment Information

Status:

☐ Student ☐ Employed ☐ Unemployed ☐ On Disability

☐ Retired ☐ Social Assistance (i.e. Ontario Works) ☐ Other

## If Employed:

| Dates Employed: | Occupation: |
|---|---|
| | |
| Employer/Company Name: | Employer/Company Phone Number: |
| | |
| Employer/Company Address: | |
| Benefit Provider (if applicable): | |

Did you miss work due to a gastric-band related injury? ☐ Yes ☐ No

If yes:

Approximately how much work have you missed? _____

How much income was lost during this time? (hours, monthly, or annually, depending on your circumstance)

_____

Did you receive any income assistance (short/long-term disability) for you absence? ☐ Yes ☐ No

If yes, please provide the details of amounts and time period:

## If Retired:

Do you currently receive the Canada Pension Plan (CPP) benefits? ☐ Yes ☐ No

Do you currently receive social assistant payments? (i.e. in Ontario, the "Ontario Works" or "Ontario Disability Support Payments")
☐ Yes ☐ No

Do you currently have any health benefits or insurance coverage for your gastric-band related injuries?
☐ Yes ☐ No

If yes:

Who is the provider? _____

What is the plan or certificate number? _____

## Authorizations and Acknowledgments

Do you authorize our office to correspond with and collect medical data pertaining to your gastric-band from the physicians and health authorities listed in this questionnaire? ☐ Yes ☐ No

Do you authorize our office to share your PHN, full name, and date of birth with the Ministry of Health for the purpose of reviewing your medical data relating to your gastric-band? ☐ Yes ☐ No

We are recommending that you contact your healthcare providers and physicians listed in this questionnaire to do the following:

1. Request that the respective medical office maintain your medical records beyond 10 years from the date of your first consultation concerning the gastric band, and until such further time as you authorize otherwise, in conjunction with this products liability class action against the manufacturers; and

2. Request that copies of your medical records be sent to you by email, fax or post, from the date of the first consultation with a doctor concerning your gastric band up until the date of this questionnaire.

☐ I acknowledge that I have read and understood this recommendation.

Signature

Date