

Exhibit A
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**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION**

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|---|---|--|
| IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION |) | MDL 2804 |
| |) | |
| THIS DOCUMENT RELATES TO: |) | |
| |) | |
| <i>NAS Cases</i> |) | Master Docket Case No. 1:17-md-2804 |
| |) | Hon. Dan Aaron Polster |

NAS PLAINTIFF FACT SHEET

The term “NAS Plaintiff” refers to the minor plaintiff on whose behalf the Named Plaintiff has brought this lawsuit and who claims to have suffered neonatal abstinence syndrome and related injuries.

Named Plaintiff: _____
(Last Name) (First Name)

NAS Plaintiff: _____
(Last Name) (First Name)

Case number: _____

In completing this Fact Sheet, you are under oath and must provide information that is true and correct **to the best of your knowledge**. Please answer every question and do not leave any blanks throughout this Fact Sheet. If you do not have room in the space provided to complete your answer, please attach as many sheets of paper as necessary to fully answer the questions.

The term “communication” and/or “correspondence” shall mean and refer to any oral, written or electronic transmission of information, including, without limitation, meetings, discussions, conversations, telephone calls, memoranda, letters, e-mails, text messages, conferences, or seminars or any other exchange of information.

The term “identify” or “identity” with respect to persons, means to give, to the extent known, the person’s full name, their present or last known addresses and phone numbers.

The term “person” means natural person, as well as corporate and/or governmental entity.

The terms “Relating to,” “relate to,” “referring to,” “refer to,” “reflecting,” “reflect,” “concerning,” or “concern” shall mean regarding, concerning, discussing, embodying, describing, summarizing, containing, constituting, showing, mentioning, reflecting, pertaining to, dealing with, relating to, referring to in any way or manner, or in any way logically or factually, connecting with the matter described in that paragraph of these demands, including documents attached to or used in the preparation of or concerning the preparation of the documents.

The term “you” refers to the Named Plaintiff.

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I. CASE INFORMATION

1. Name of person completing this form:

Last Name: _____

First Name: _____

Middle Name: _____

2. State your address, telephone numbers, and e-mail address:

- a. Address:

Street: _____

City: _____

State: _____

Zip Code: _____

- b. Home Telephone: _____ Mobile: _____

- c. Primary e-mail: _____

3. If you are completing this questionnaire in a representative capacity, on behalf of the NAS Plaintiff, please state the following:

- a. Individual or estate you are representing: _____

- b. If you were appointed as a representative by a court, state the court:

- c. Date of appointment: _____

- d. State your relationship with the represented person:

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II. BIRTH MOTHER INFORMATION

The term "Birth Mother" refers to the woman who gave birth to the individual claiming injury from neonatal abstinence syndrome.

1. Provide the following information about the Birth Mother:
 - a. Full Name (First, Middle, Last): _____
 - b. Any other names (*e.g.*, maiden name or alias) the Birth Mother has used or by which the Birth Mother has been known and the dates she used those names:
 Name: _____ Dates Used: _____
 - c. Social Security Number: _____
 - d. Address: _____
 - e. State the number of years the Birth Mother has lived at her present address: _____
2. The Birth Mother's Date and Place of Birth: _____
3. Is the Birth Mother currently, or has she ever been, married? Yes: _____ No: _____

If "yes," for each spouse, please state the following:

| Name of Spouse | Date of Birth | Current or Last Known Address | Date Marriage Began | Date Marriage Ended |
|----------------|---------------|-------------------------------|---------------------|---------------------|
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4. Does the Birth Mother have any other children who were born with birth defects or other health conditions present at birth? For each such child, list the following:

| Child's Name | Date of Birth |
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5. Identify the following information for each high school, college, university, vocational school, or other educational institution the Birth Mother has attended:

| Name of School | Address | Dates of Attendance | Degree Awarded |
|----------------|---------|---------------------|----------------|
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6. For the Birth Mother's current employer (or her last employer if unemployed) and each employer for the last ten (10) years, state the following:

| Name of Employer | Address of Employer | Dates of Employment | Occupation/Job Title |
|------------------|---------------------|---------------------|----------------------|
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7. If the Birth Mother has been convicted of a felony in the last ten (10) years, state:
- a. the nature of the crime: _____
 - b. date of the crime: _____
 - c. location of the crime: _____
8. If the Birth Mother has been convicted of any crime involving the use, possession, or sale of any controlled substances, including prescription opioids, state:
- a. the nature of the crime: _____
 - b. date of the crime: _____
 - c. location of the crime: _____

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III. INSURANCE AND CLAIM INFORMATION

1. Identify any person, insurance company, or other entity, including Medicare or Medicaid, that provided medical coverage to the Birth Mother (either directly or through group coverage, including any employer) or paid medical bills on her behalf, beginning seven years before the birth of the NAS Plaintiff through the present.

| Name of Entity | Policy Number | Name of Policy Holder/Insured | Dates of Coverage |
|----------------|---------------|-------------------------------|-------------------|
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2. Identify any person, insurance company, or other entity, including Medicare or Medicaid, that provided medical coverage to the NAS Plaintiff (either directly or through group coverage, including any employer) or paid medical bills on the NAS Plaintiff's behalf, beginning from the NAS Plaintiff's birth through the present.

| Name of Entity | Policy Number | Name of Policy Holder/Insured | Dates of Coverage |
|----------------|---------------|-------------------------------|-------------------|
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3. In the past 10 years, has the Birth Mother filed social security disability claims (SSI or SSD) or filed a disability claim with a private insurer?

Yes: _____ No: _____ If "yes," please state:

Year the claim was filed: _____

With whom and where the claim was filed: _____

Nature of disability: _____

Period of disability: _____

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IV. BIRTH MOTHER MEDICAL BACKGROUND AND SOCIAL HISTORY

1. *Other than prescription opioids*, for each prescription medication the Birth Mother has taken regularly (*i.e.*, over the course of one month or more) in the ten (10) years prior to giving birth to the NAS Plaintiff, identify the following information:

| Name of Prescription Medication Used on a Regular Basis | Name and Address of Doctor(s) that Prescribed the Medication | Name and Address of Pharmacy where Prescription was Filled | Approximate Dates/Years Taken | Why Birth Mother was taking the Medication |
|--|---|---|--------------------------------------|---|
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2. Has the Birth Mother ever used tobacco in any form one (1) year before or at any time after the birth of the NAS Plaintiff?

Yes: _____ No: _____ If “yes,” check the answer and state the following:

_____ Birth Mother is a **past** tobacco user

Type(s) of tobacco used: _____

Date on which Birth Mother began using tobacco: _____

Date on which Birth Mother ceased using tobacco: _____

Amount of tobacco used: _____ per day for _____ years.

_____ Birth Mother is a **current** tobacco user

Type(s) of tobacco used: _____

Date on which Birth Mother began using tobacco: _____

Amount of tobacco used: _____ per day for _____ years.

3. Did the Birth Mother ever consume alcohol in any form in the time period between one (1) year before and one (1) year after the birth of the NAS Plaintiff?

Yes: _____ No: _____

If “yes,” complete the answer below that best describes the Birth Mother’s alcohol consumption in the time period between one (1) year before and one (1) year after the birth of the NAS Plaintiff:

_____ drinks per week; or

_____ drinks per month; or

_____ drinks per year; or

Other (describe alcohol consumption): _____

4. Excluding opioids, did the Birth Mother consume any recreational drugs (or prescription drugs used for a nonmedical purpose) in any form in the time period between one (1) year before and one (1) year after the birth of the NAS Plaintiff?

Yes: _____ No: _____

If “yes,” list the drug type, amount, and date of consumption: _____

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5. Has the Birth Mother ever been the subject of an investigation by Child Protective Services (or similar social services agency) relating to the custody of her children?

Yes: _____ No: _____

If "yes," describe the reason: _____

V. BIRTH MOTHER OPIOID INFORMATION

1. To the extent a licensed healthcare provider prescribed opioids to the Birth Mother (including medication-assisted therapy during the Birth Mother's pregnancy), please provide:

Diagnosis supporting the prescription: _____

Opioid prescribed: _____ Dates taken: _____

Prescribing Healthcare Provider: _____

Prescribing Healthcare Provider address: _____

Dispensing Pharmacy: _____

Dispensing Pharmacy Address: _____

2. State the following information related to the Birth Mother's use of non-prescribed opioids, including any prescription pills used without a prescription written to the Birth Mother and any heroin or street fentanyl.

Non-prescribed opioid used: _____

Frequency used: _____ Dates taken: _____

Non-prescribed opioid obtained from: _____

Non-prescribed opioid used: _____

Frequency used: _____ Dates taken: _____

Non-prescribed opioid obtained from: _____

Non-prescribed opioid used: _____

Frequency used: _____ Dates taken: _____

Non-prescribed opioid obtained from: _____

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3. Please provide the following information regarding any witnesses to the Birth Mother's use of prescribed or non-prescribed opioids use:

| Witness Name | Witness Address | Opioid Use Witnessed (Type of Opioid and Relevant Dates) |
|--------------|-----------------|---|
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VI. BIOLOGICAL FATHER INFORMATION

1. Provide the following information about the NAS Plaintiff's biological father:
- a. Full Name (First, Middle, Last): _____
 - b. Any other names the biological father has used or by which he has been known and the dates he used those names:
Name: _____ Dates Used: _____
 - c. Social Security Number: _____
 - d. Address: _____
2. Did the biological father ever consume alcohol in any form in the time period between one year before and the birth of the NAS Plaintiff?
- Yes: _____ No: _____

If "yes," complete the answer below that best describes the biological father's alcohol consumption in the time period between one (1) year before and one (1) year after the birth of the NAS Plaintiff:

_____ drinks per week; or

_____ drinks per month; or

_____ drinks per year; or

Other (describe alcohol consumption): _____

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3. Did the biological father consume any recreational drugs (or prescription drugs used for a nonmedical purpose), including non-prescribed opioids, in any form in the time period between one (1) year before and one (1) year after the birth of the NAS Plaintiff?

Yes: _____ No: _____

If "yes," list the drug type, amount, and date of consumption: _____

VII. NAS PLAINTIFF CLAIM INFORMATION

1. Do you allege that you represent an individual that suffered, or is currently suffering from, physical and/or bodily injury as a result of neonatal abstinence syndrome?

Yes: _____ No: _____

If "yes," describe the physical and/or bodily injuries, and state whether the NAS Plaintiff currently suffers from the injury:

2. Do you claim that the Birth Mother's use of opioids during pregnancy caused any psychological, psychiatric (including depression), cognitive, or mental injury to the NAS Plaintiff? If "yes," describe the psychological, psychiatric, cognitive, or mental injury:

3. Do you claim that the Birth Mother's use of opioids during pregnancy caused any physical injury or birth defect to the NAS Plaintiff? If "yes," describe the physical injury or birth defect:

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4. Do you claim that the Birth Mother's use of opioids during pregnancy caused any developmental delay type injury to the NAS Plaintiff? If "yes," describe the developmental delay type injury:

VIII. NAS PLAINTIFF MEDICAL PROVIDERS AND HOSPITALIZATIONS

1. Identify the name and address of the NAS Plaintiff's current family and/or primary care physician:

2. Identify all healthcare providers who examined, treated, or provided consultation to the NAS Plaintiff from the NAS Plaintiff's birth to the present for any reason, and for each consultation, examination, or treatment, state the following information:

| Healthcare Provider's Name | Healthcare Provider's Specialty | Address | Dates/Years of Visits | Reason for Visit |
|----------------------------|---------------------------------|---------|-----------------------|------------------|
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3. For each hospitalization at any time from birth to the present, state the following information:

| Name of Hospital | Address and Telephone Number of Hospital | Admission Date(s) | Reason for Admission |
|------------------|--|-------------------|----------------------|
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4. Identify the following for each pharmacy that has dispensed medication for the NAS Plaintiff since birth:

| Name of Pharmacy | Address of Pharmacy | Telephone Number of Pharmacy | Name of Medication Dispensed | Dates/Years You Used Pharmacy |
|------------------|---------------------|------------------------------|------------------------------|-------------------------------|
| | | | | |
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5. Identify all social services providers (including social workers, early childhood educators, child protective services employees, or other home visitors) who have evaluated, provided care or treatment for, or otherwise interacted with the NAS Plaintiff from birth to the present for any reason, and for each evaluation, consultation, examination, or treatment, state the following information:

| Social Services Provider's Name | Social Services Provider's Specialty | Address | Dates/Years of Interaction | Reason for Interaction |
|---------------------------------|--------------------------------------|---------|----------------------------|------------------------|
| | | | | |
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IX. DOCUMENTATION

1. **Documents in your possession:** If you have any of the following materials in your possession (and they are not subject to any privilege, including but not limited to attorney-client privilege or work-product protection), please attach a copy to this Fact Sheet.
- A. A copy of any document constituting the appointment of you or the Named Plaintiff as a representative of the NAS Plaintiff.
 - B. All diagnostic tests and test results, including original films or video of ultrasounds, MRIs, x-rays, CT scans, etc., taken of the NAS Plaintiff from birth to the present.
 - C. Copies of all documents from physicians, healthcare providers, social services providers, or others related to the NAS Plaintiff's neonatal abstinence syndrome and alleged injuries.
 - D. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation in your possession (excluding information subject to the attorney-client privilege or work-product protection).
 - E. All documents relating to the NAS Plaintiff's neonatal abstinence syndrome and alleged injuries, including but not limited to medical records, medical bills, prescriptions, diaries,

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notes, rehabilitation instructions, etc., whether made by you or any other person or entity, other than your attorney in this action.

F. All photographs, drawings, slides, or videos relating to the NAS Plaintiff's alleged injury and the limits the alleged injury has placed on the NAS Plaintiff's life.

G. All journals, diaries, notes, letters, or emails written by you, the Birth Mother or the NAS Plaintiff from the NAS Plaintiff's birth to the present.

2. **Authorizations:**

A. Please sign and attach to this Fact Sheet the authorizations for release of records appended hereto for all healthcare providers and social services providers listed in your responses to this Fact Sheet.

B. Please attach to this Fact Sheet a copy of each authorization for the release of records that you have submitted to any health care provider listed in this fact sheet.

HIPAA Authorization Letter

To Use and Disclose Protected Health Information

| | | |
|------------------------|---------------------------------|-----------------------------|
| Patient Name: _____ | Patient DOB: ____ / ____ / ____ | Patient SSN: _____ |
| Patient Address: _____ | | |
| City: _____ | State: _____ | Zip: _____ Telephone: _____ |

I hereby authorize the release of my Protected Health Information from:

Provider or Facility Name and Address: _____

Provider or Facility Name and Address: _____

Provider or Facility Name and Address: _____

Protected Health Information may be disclosed to:

| |
|-------|
| _____ |
| _____ |
| _____ |
| _____ |

Intended use or purpose of disclosure: _____

| |
|-------|
| _____ |
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Protected Health Information to be disclosed (check from the following):

- _____ All records/bills in your possession for all dates of service
- _____ All records/bills in your possession for the following date(s) of service: _____
- _____ Certain records/bills in your possession, as specified below:
 - Date(s) of service: _____
 - Specific records: _____

This Authorization Letter includes the release of the following records (Please check, if applicable):

| | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Alcohol/drug Treatment | <input type="checkbox"/> | Mental Health Records |
| <input type="checkbox"/> | Sexually Transmitted Infections/Diseases | <input type="checkbox"/> | HIV/AIDS Information |
| <input type="checkbox"/> | Genetic Testing | <input type="checkbox"/> | Communicable/Non-Communicable Diseases |

- I understand that signing this Authorization Letter is voluntary. My treatment, payment, and enrollment in a health plan or eligibility for benefits will not be conditioned upon my signing of this Authorization Letter.
- I have the right to revoke this Authorization Letter at any time by writing the provider or facility listed above.
- I understand that information used or disclosed pursuant to this Authorization Letter may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I have a right to receive a copy of this Authorization Letter.
- A photocopy of this Authorization Letter shall be considered as valid.
- This Authorization Letter will be valid for one (1) year from the date of signature below.

Patient Signature or Personal Representative

Date

Printed Name, if signed by Personal Representative

Relationship to Patient