

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: MIRAPEX PRODUCTS LIABILITY) MDL No. 07-1836 (JMR/FLN)
LITIGATION)
_____)
This Documents Relates to "All Actions")
_____)

PRE-TRIAL ORDER NO. 2

(Plaintiff's Fact Sheet & Authorizations)

This Order governs the form and schedule for service of the Plaintiff's Fact Sheet and executed Authorizations for the Release of Records to be completed by all plaintiffs in all individual cases in which plaintiffs claim to have suffered an injury and/or damages as a result of ingestion of the pharmaceutical Mirapex. This Order covers (1) all cases transferred to this Court by the Judicial Panel on Multi-District Litigation pursuant to its Order of June 27, 2007; (2) all cases subsequently transferred to this Court by the Judicial Panel on Multi-District Litigation pursuant to Rule 7.4 of the Rules of Procedure of that Panel; and (3) all cases originally filed in this Court or transferred or removed to this Court.

1. All plaintiffs alleging injuries and damages as a result of ingestion of Mirapex shall serve upon Boehringer Ingelheim Pharmaceuticals, Inc. and Pfizer, Inc., et al. a Plaintiff's Fact Sheet and Authorizations for Release of Medical Records and other sources of information and records (e.g., pharmacies, employers, etc.) in the form set forth in Attachment "A".

2. Unless the parties agree otherwise or by Order of the Court, completed and verified Plaintiff's Fact Sheets, signed and dated Authorizations and all responsive documents shall be

produced on the following schedule for all cases filed in or transferred to the Multi-District Litigation No. 1836, In Re: Minnesota District Court, Mirapex Products Liability Litigation as of the date of this Order, with the exception of those previously designated as "Wave #1" trial cases. Plaintiff's Fact Sheets will be served in five (5) waves as follows: Forty-five (45) Fact Sheets by October 15, 2007; Forty-five (45) Fact Sheets by December 1, 2007; Forty-five (45) Fact Sheets by January 15, 2008; and Forty-five (45) Fact Sheets by March 1, 2008; and Forty-five (45) and/or the remainder of un-served Fact Sheets for filed cases as of the date of this order by April 15, 2008. The Fact Sheets shall be served in order based on the date of filing. In addition no "wave" or group of forty-five shall consist of more than sixty percent (60%) of cases from one individual Plaintiff's law firm.

3. Plaintiffs in individual Mirapex cases that are filed in or transferred to this MDL proceeding after the date of this Order shall provide verified Plaintiff's Fact Sheets, signed and dated Authorizations, and all responsive documents within ninety (90) days of their Transfer Order or the date on which they are filed in this proceeding.

4. Plaintiffs who fail to provide completed and verified Plaintiff's Fact Sheets, signed and dated Authorizations, and all responsive documents in their possession requested in the Plaintiff's Fact Sheet within the time period set forth hereinabove shall be given notice by and through their attorney of record email or fax from defendants' liaison counsel and shall be given thirty (30) additional days to cure such deficiency.

5. Plaintiffs shall serve the Plaintiff's Fact Sheet responses, signed and dated Authorizations and all responsive documents in their possession on defendants' liaison counsel Tracy Van Steenburgh and Scott Smith, of Halleland, Lewis, Nilan and Johnson, P.A., and Peter J. Goss and Joseph M. Price of Faegre and Benson.

6. Authorizations shall be dated and signed identifying the Custodian of Records or provider of care. Defendants may only use Authorizations for health care providers and other sources of information and records (e.g., pharmacies, employers, etc.) specifically identified on the Authorization. The Defendants' Liaison Counsel shall post the records received pursuant to the use of Authorizations on a secure website maintained by the defendants' liaison counsel's vendor and notify claimant's attorney and plaintiff's liaison by email of the posting. Plaintiff's counsel in a particular case and plaintiff's liaison counsel may access that website to obtain copies of their client's medical records at their cost.

7. If defendants wish to obtain an Authorization to obtain records from a source that an Authorization has not been provided for with the completed Fact Sheet, defendants shall provide plaintiff's counsel for that particular case written notice of their request for an Authorization to obtain records from a specific source. Plaintiff's counsel then has ten (10) business days to either provide requested Authorization or object to the use of an Authorization to obtain records from that particular source. In the event that plaintiff's counsel objects to the use of an Authorization to obtain records, plaintiff's counsel and defendants' counsel shall meet and confer in an attempt to resolve the objection. If counsel are unable to resolve the objection, plaintiff shall file a motion for a protective order within twenty (20) days of plaintiff's written objection to providing an Authorization to request medical records to the defendants.

8. Plaintiff's responses to Plaintiff's Fact Sheet shall be treated as answers to interrogatories under Federal Rule of Civil Procedure 33 and responses to request for production of documents under Federal Rule of Civil Procedure 34 and shall be supplemented in accordance with Federal Rule of Civil Procedure 26.

This Order shall be posted on the Court's website for MDL 1836 located at www.mnd.uscourts.gov. Counsel unable to access the Court's website for MDL 1836 may contact the Clerk of Court for information on obtaining a copy of this Order.

Dated: September 5, 2007

s/ Franklin L. Noel
Magistrate Judge Franklin L. Noel

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**IN RE: MINNESOTA DISTRICT COURT
MIRAPEX® PRODUCT LIABILITY LITIGATION**

PLAINTIFF'S FACT SHEET

Each Plaintiff who used Mirapex® (“Mirapex”) must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as possible. You may, and should, consult with your attorney if you have any questions regarding the completion of this Fact Sheet.

If you are completing the Fact Sheet for someone who has died or who cannot complete it him/herself, please answer as completely as you can for that person. You may attach as many sheets of paper as necessary to answer these questions.

I. Case Information

A. Please state the following for the civil action that you filed:

1. Case caption: _____
2. Civil Action No: _____
3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

Name

Firm

Street Address

City, State and Zip Code

Telephone Number

Fax Number

E-mail address

B. If you are completing this Fact Sheet 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 are you representing the person? _____
4. If a court appointed you to act on behalf of the estate of the deceased person or minor, please state the court and date of appointment: _____

5. Your relationship to deceased or represented person: _____

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

The remainder of this Fact Sheet requests information about the person who used Mirapex. If you are completing this Fact Sheet for someone else, please assume that "you" or "your" means the person who used Mirapex.

II. Personal Information

A. Name: _____

B. If you have ever used other names, please provide the names and dates of use: _____

C. Current Address: _____

D. How long have you been living at this address? _____

E. List any prior addresses during the last ten (10) years and the dates when you lived at those addresses. _____

[Please attach additional pages as necessary.]

F. Social Security Number: _____

G. Date and place of birth: _____

H. Sex: Male Female

I. Marital Status: _____

J. If applicable, name of current spouse and date of marriage: _____

K. If applicable, name of former spouse(s) and date(s) of marriage and date(s) and jurisdiction(s) of divorce(s):

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

M. Current employer:

Name: _____
Address: _____
Job Duties: _____
Job Title: _____
Dates Employed: _____

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Full-time or Part-time: _____
 Yearly Compensation: _____
 Name of Supervisor: _____

Are you making a claim for lost wages? _____ Yes _____ No

Are you making a claim for lost earning capacity? _____ Yes _____ No

Are you making a claim for any business losses? _____ Yes _____ No

Are you making a claim for lost use of money? _____ Yes _____ No

N. Please complete the following information regarding any employers (other than your current employer) that you have had in the last ten (10) years:

Name: _____
 Address: _____
 Job Duties: _____
 Job Title: _____
 Dates Employed: _____
 Full-time or Part-time: _____
 Yearly Compensation: _____
 Name of Supervisor: _____

[Please attach additional pages as necessary.]

O. Please provide the following information about your education:

1. High School

Name: _____
 Address: _____
 Grade completed: _____
 Year graduated: _____

2. Did you attend school beyond high school? _____ Yes _____ No

If "yes," please complete the following for each school that you attended after high school:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or primary field

P. In the past five years, have you used a computer for:

1. Online gambling? _____ Yes _____ No

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If "Yes," please list each computer you have used in the past five years and indicate whether you still have access to each: _____

If "Yes," and you have sold, donated, or otherwise transferred possession of any of the computers listed in your response above, please provide the date of the transfer, to whom it was transferred, and whether you backed-up any files before the transfer: _____

2. Sending emails or drafting documents that discussed Mirapex or impulse control disorders?

_____ Yes _____ No

If "Yes," please list each computer you have used in the past five years and indicate whether you still have access to each: _____

If "Yes," and you have sold, donated, or otherwise transferred possession of any of the computers listed in your response above, please provide the date of the transfer, to whom it was transferred, and whether you backed-up any files before the transfer: _____

3. Visiting websites that discussed Mirapex or impulse control disorders?

_____ Yes _____ No

If "Yes," please list each computer you have used in the past five years and indicate whether you still have access to each: _____

If "Yes," and you have sold, donated, or otherwise transferred possession of any of the computers listed in your response above, please provide the date of the transfer, to whom it was transferred, and whether you backed-up any files before the transfer: _____

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4. Posting on internet chat rooms that discussed Mirapex or impulse control disorders?
_____ Yes _____ No

If "Yes," please list each computer you have used in the past five years and indicate whether you still have access to each: _____

If "Yes," and you have sold, donated, or otherwise transferred possession of any of the computers listed in your response above, please provide the date of the transfer, to whom it was transferred, and whether you backed-up any files before the transfer: _____

5. If you answered "Yes" to any of questions 1-4, do you own any zip drives, flash drives, external hard drives, or other storage devices containing files from computers you currently or have previously owned?
_____ Yes _____ No

6. If you have ever sent or received any email relating to Mirapex or impulse control disorders, please list all email addresses and internet service providers you have used in the past five years, as well as the names and email addresses of those who sent you or received from you any such email: _____

7. If you have ever visited any website containing information about Mirapex, dopamine agonists, pathological gambling, compulsive behavior, or impulse control disorders, please state the internet address and, to the best of your ability, the dates you visited: _____

8. If you have ever visited any chat rooms where Mirapex, dopamine agonists, pathological gambling, compulsive behavior, or impulse control disorder were discussed, please state the internet address and, to the best of your ability, the dates you visited: _____

9. If you have you ever posted on any chat rooms where Mirapex, dopamine agonists, pathological gambling, compulsive behavior, or impulse control disorder were discussed, please provide the date(s) of the post(s) and the username(s) under which

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you posted: _____

10. Have you ever maintained a web site or blog? _____ Yes _____ No

If "Yes," please provide the address(es): _____

11. Have you ever visited an online casino, placed a wager over the internet, or otherwise gambled online? _____ Yes _____ No

If "Yes," please list all websites and email addresses and provide approximate dates: _____

Q. Have you ever given a speech, television or radio interview, or written a letter, essay or article on the subject of Mirapex and pathological gambling or other impulse control disorders? _____ Yes _____ No

If "Yes," please describe it, give the date(s) and attach a copy of the letter, essay, article or transcript: _____

R. Have you applied for worker's compensation, social security, state, federal, or Veterans' disability benefits in the past ten (10) years? _____ Yes _____ No

If "Yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as possible.

1. To what agency or company did you submit your application (e.g., Social Security Administration): _____
2. Date (or year) of application: _____
3. Type of benefits: _____
4. Amount awarded: _____
5. Disabling Condition: _____
6. Basis of your application/nature of your claim: _____
7. If denied, reason for denial: _____

S. Have you received or applied for benefits under any health, medical or accident insurance policy in the past ten (10) years for Mirapex or any condition you claim is related to your use of Mirapex? _____ Yes _____ No

If "Yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as possible.

1. Insurer: _____
2. Type of insurance: _____
3. Policy number: _____
4. Dates of coverage: _____

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[Please attach additional pages as necessary.]

- T. Were you ever rejected or discharged from military service for any reason relating to your health, mental, emotional or physical condition or disability?
 Yes No

If "Yes," please state the reason for the health-related rejection or discharge and when this happened: _____

- U. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any physical, mental or emotional illness, injury? Yes No

If "Yes," please complete the following for each lawsuit or claim. If you cannot recall all of the details regarding such lawsuit(s)/claim(s), please provide as much information as possible.

1.Date (or year) of filing/petition: _____

2.Court where petition filed: _____

3.Name and address of counsel who represented you (if applicable): _____

4.Relief sought: _____

5.Relief obtained: _____

- V. Have you ever filed or petitioned for bankruptcy? Yes No

If "Yes," please complete the following for each bankruptcy:

1. Date (or year) of filing/petition: _____

2. Court where petition filed: _____

3. Name and address of counsel who represented you (if applicable): _____

4. Relief sought: _____

5. Relief obtained: _____

[Please attach additional pages as necessary.]

- W. In your current marriage, have you ever filed, prepared, or been the subject of a petition for separation, divorce, or dissolution of marriage? Yes No
 Not Applicable

If "Yes," please complete the following for each application. If you cannot recall all of the details regarding such filing/petitions, please provide as much information as possible.

1.Date (or year) of filing or petition for separation, divorce, or dissolution of marriage (if applicable): _____

2.Court where filed (if applicable): _____

3.Name and address of counsel who represented you (if applicable): _____

4.Relief sought: _____

5.Intermediate and/or final disposition: _____

[Please attach additional pages as necessary.]

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- X. **Have you ever contacted any of the defendants in this litigation or any of their corporate affiliates for any reason?** _____ Yes _____ No

If "Yes," please indicate the date(s) of contact, whom you spoke with, and the subject matter of the conversation(s) :

III. Your Health Care Providers

- A. Please provide the following information for each healthcare provider that you have seen or who has treated you during the last ten (10) years. (Please note that "healthcare provider" includes any doctor, osteopath, psychiatrist, psychologist, chiropractor, nurse practitioner, counselor, or other person who provided any type of medical, psychiatric, psychological counseling or other health care service to you.) If you cannot recall all of the details regarding the healthcare providers that you have seen, please provide as much information as possible.

1. Name and Specialty (if any): _____
 Address: _____
 Phone: _____
 Reason(s) for visit(s): _____
 Medications prescribed or recommended: _____

2. Name and Specialty (if any): _____
 Address: _____
 Phone: _____
 Reason(s) for visit(s): _____
 Medications prescribed or recommended: _____

[Please attach additional pages as necessary.]

IV. Your Pharmacies

- A. Please provide the following information for each Pharmacy that has dispensed prescription medication to you during the last ten (10) years.

1. Name: _____
 Address: _____
 Phone: _____

[Please attach additional pages as necessary.]

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V. Family History

A. To the best of your knowledge have any of your first degree family relatives (defined as: siblings, parents, grandparents, aunts, uncles or your children) had any of the following medical conditions:

Condition	Yes	No	I don't know
Parkinson's Disease			
Restless Legs Syndrome			
Pathological Gambling			
Impulse Control Disorder			
Obsessive Compulsive Disorder			
Alcoholism			
Depression			
Substance Abuse			
Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder			
Bipolar Disorder/Manic Depression			
Eating Disorder			
Other Psychiatric/Psychological Disorder			

If "Yes," please complete the following:

Type of health problem: _____
 Date and cause of death, if applicable: _____

[Please attach additional pages as necessary.]

B. To the best of your knowledge, have any of your first degree relatives engaged in any of the following behaviors to a degree where friends or family of that relative found the behavior to be excessive:

Behavior	Yes	No	I Don't Know
Use of alcohol			
Use of illegal drugs			
Use of prescription medication			
Spending/Shopping			
Viewing Pornography			
Sex or sexual thoughts			
Gambling			
Over-eating/Binge eating			

If "Yes," please complete the following:

Briefly describe the behavior: _____
 Frequency/Dates of behavior: _____
 Treatment received (if any): _____

[Please attach additional pages as necessary.]

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VI. Your Medical Background

A. Height: _____

B. Current 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

4. What is the most you have ever smoked for any three-month period in your life?

5. Have you ever used any other form of tobacco (snuff, dipping, cigars)?
_____ Yes _____ No _____ I don't know

If "yes," please identify:

a. What form: _____

b. Dates of use: _____

c. Amount of use: _____

6. Have you ever tried to quit smoking? _____ Yes _____ No

If "Yes," please indicate approximate dates that you quit, length of period during which you abstained, and whether any counseling or smoking cessation aids were used: _____

D. Alcohol Consumption

1. How much alcohol do you drink in a typical week?

_____ None

_____ 1-5 drinks per week

_____ 6-10 drinks per week

_____ 10 or more drinks per week

2. What's the most alcohol you've consumed over any three-month period of your life?

_____ None

_____ 1-5 drinks per week

_____ 6-10 drinks per week

_____ 10 or more drinks per week

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3. Has anyone ever told you they were concerned about your drinking?

_____ Yes _____ No

If "Yes," please indicate who told you that and when: _____

E. Illicit Drug Use

1. Please indicate whether you have ever used any of the following more than seven times, and if so, please indicate frequency of use and provide approximate dates of use:

a. Marijuana _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

b. Cocaine (incl. powder and rock or "crack"): _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

c. Amphetamines/Methamphetamine: _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

d. MDMA (Ecstasy) _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

e. LSD: _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

f. Heroin: _____ Yes _____ No
Frequency of use: _____
Dates of use: _____

2. Please indicate whether you have taken the following medications without a prescription more than three times within a six-month period, and if so, please indicate frequency of use and provide approximate dates of use:

a. Prescription narcotics and pain medications (for example, Oxycontin, Percocet, Vicodin) _____ Yes _____ No

Frequency of use: _____

_____ Dates of use: _____

b. Prescription stimulants (for example, Ritalin, Adderall) _____ Yes _____ No

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Frequency of use: _____
Dates of use: _____

c. Barbiturates and prescription anxiety drugs (for example, Valium, Xanax)
_____ Yes _____ No
Frequency of use: _____
Dates of use: _____

3. Have you ever used an over-the-counter medication in a manner other than as directed by the product's label? _____ Yes _____ No
Medication: _____
Frequency of use: _____
Dates of use: _____

[Please attach additional pages if necessary.]

F. Counseling and 12-Step Programs

1. Have you ever participated in Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous, or another "12-step" program related to substance abuse or an impulse control disorder? _____ Yes _____ No
If "Yes," please provide name(s) of organization(s), approximate dates of participation, and meeting location(s): _____

[Please attach additional pages if necessary.]

2. Have you ever sought counseling other than through a "12-step" program for substance abuse or an impulse control disorder? _____ Yes _____ No
If "Yes," please provide name(s) and address(es) of counselor(s) and approximate dates of counseling: _____

[Please attach additional pages if necessary.]

G. Your Current Medications

Name: _____
Dosage: _____
Condition for which taking medication: _____
Prescribing Healthcare Provider: _____

Name: _____
Dosage: _____

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Condition for which taking medication: _____
 Prescribing Healthcare Provider: _____

[Please attach additional pages if necessary.]

H. Hospitalizations

Please provide the following information for each hospitalization that you have had during the last ten (10) years. If you cannot remember all of the details, please list as much information as possible.

1. Name of hospital: _____
 Address: _____
 Phone: _____
 Reason(s) for hospitalization(s): _____

2. Name of hospital: _____
 Address: _____
 Phone: _____
 Reason(s) for hospitalization(s): _____

[Please attach additional pages if necessary.]

I. Have you ever been diagnosed as having any of the following medical conditions:

Condition	Yes	No	I don't know
Parkinson's Disease			
Restless Legs Syndrome			
Pathological Gambling			
Impulse Control Disorder			
Obsessive Compulsive Disorder			
Alcoholism			
Depression			
Drug Addiction			
Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder			
Bipolar Disorder/Manic Depression			
Other Psychiatric/Psychological Disorder			
Other major medical condition(s)			

If you responded "Yes" to any of the above, please provide the following information for each condition. If you cannot remember all of the details, please provide as much information as you can.

Type of condition and date of diagnosis: _____
 Diagnosing healthcare provider: _____
 How long did condition last: _____

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[Please attach additional pages if necessary.]

- J. To the best of your knowledge, have you ever experienced any of the following behaviors to a degree that you, your friends, or family felt were excessive:

Behavior	Yes	No	I Don't Know
Use of alcohol			
Illicit drugs			
Spending/Shopping			
Pornography			
Sex or sexual thoughts			
Gambling			
Over-eating/Binge eating			

If you responded "Yes" to any of the above, please provide the following information for each condition. If you cannot remember all of the details, please provide as much information as you can.

Briefly describe the behavior: _____

Frequency/Dates of behavior: _____

Who told you it was excessive:

Treatment received (if any): _____

[Please attach additional pages if necessary.]

VII. Mirapex

- A. Have you ever taken Mirapex? _____ Yes _____ No

If "Yes," please complete the following:

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Condition For Which Mirapex Taken	Dosage/Dates of Use (Include all start/stop dates and dosage changes)	Prescribing Health Care Provider (name and address)	Dispensing Pharmacy (name and address)

B. Did your doctor(s) ever give you any free samples of Mirapex? ____ Yes ____ No

If “Yes,” please indicate which doctor(s), how many samples were provided, and the dates you took them:

C. What effect, if any, did Mirapex have on your symptoms? _____

D. Were you given any **written materials** containing warnings or other information regarding your use of Mirapex? ____ Yes ____ No ____ I don’t know

1. If “yes,” when did you receive the information? _____

2. Who gave you the information? _____

3. If you no longer have the written information in your possession, please describe the written information that you received to the best of your ability. _____

E. When and how did you first learn about the possible association between Mirapex and pathological gambling or other impulse control disorders? _____

F. Before taking Mirapex, had you ever gambled? ____ Yes ____ No

If “Yes,” please describe your gambling history, including approximate dates, types of games played and/or wagers placed, names of casinos visited (including online), names of bookmakers with whom you placed wagers, and frequency of gambling activity: _____

G. Did your doctor give you any **oral instructions**, warnings or other information regarding your use of Mirapex? ____ Yes ____ No ____ I don’t know

1. If “Yes,” when did you receive them? _____

2. Who gave them to you? _____

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3. Please state the information you received: _____

VIII. Other Medications Taken

A. Have you ever taken any of the following medications?

Medications	Yes/No				
Cogentin (aka Benztropine Mesylate)					
Artane (aka Trihexyphenidyl/HCl)					
Lardopa (aka Levodopa)					
Levodopa					
Dopar (aka Levodopa)					
Atamet (aka Carbidopa/Levodopa)					
Sinemet (aka Carbidopa/Levodopa)					
Sinemet CR (aka Carbidopa/Levodopa)					
Stalevo (aka Carbidopa/Levodopa)					
Comtan (aka Entacapone)					
Tasmar (aka Tolcapone)					
Parlodel (aka Bromocriptine)					
Dostinex (aka Cabergoline)					
Permax (aka Pergolide)					
Requip (aka Ropinirole)					
Deprenyl (aka Selegiline)					
Eldepryl (aka Selegiline)					

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Medications	Yes/No				
Symmetrel (aka Amantadine)					

1. Did your doctor provide you any free samples? _____ Yes _____ No

For each medication for which you received samples, indicate type of medication, identity of doctor who prescribed, and approximate date(s) medication was given:

2. Did you ever take a different dose of the medication than your doctor had prescribed? _____ Yes _____ No

If "Yes," please explain:

_____ [Please attach additional pages if necessary.]

B. Please list any prescription, over-the-counter drug, dietary supplement, vitamin, or herbal remedy that you were taking during the time you were taking Mirapex.

Name of Product or Substance				

C. Please list any other treatments (surgery, life-style and/or behavior modification, holistic/alternative therapies) received or undertaken during the time you were taking Mirapex: _____

IX. Physical Injuries or Illness

A. If you are making a claim for physical injuries or illness from taking Mirapex, please describe the following:

1. General nature of injuries or illness: _____

2. Please describe the course of your physical injuries or illnesses, including when it started, how it progressed (if at all) and what (if anything) made it better or worse:

3. How you first became aware of the physical injuries or illness: _____

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4. Whether those physical injuries or illness are continuing: _____

Did you see a healthcare provider for the physical injuries or illness listed above?

_____ Yes _____ No _____ I don't know

If "Yes," please complete the following for each healthcare provider:

- a. Name:
- b. Address:
- c. 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

[Please attach additional pages if necessary.]

X. Emotional Distress, Psychological Injuries or Harm

A. Are you making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Mirapex? _____ Yes _____ No

B. If you are making a claim for mental, emotional, psychological or psychiatric injuries or illness from your use of Mirapex, please provide the following information:

1. General nature of mental, emotional, psychological or psychiatric injuries or illness:

2. Please describe the course of your mental, emotional, psychological or psychiatric injuries or illnesses, including when it started, how it progressed (if at all) and what (if anything) made it better or worse: _____

3. How you first became aware of this mental, emotional, psychological or psychiatric injuries or illness: _____

4. Whether (and if so, how) this mental, emotional, psychological or psychiatric injuries or illness has changed over time: _____

C. If you have seen a healthcare provider for treatment of this mental, emotional, psychological or psychiatric injury or illness, please provide the following information:

1. Name: _____

2. Address: _____

3. Date of first consultation with that healthcare provider: _____

4. Date of last consultation: _____

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5. Do you plan to continue to consult with that healthcare provider? ____Yes ____No

XI. Prior Treatment

If you have experienced, or been treated for, any mental, emotional, psychological, or psychiatric condition or problem (including depression) prior to your use of Mirapex, please complete the following:

Condition	Dates of treatment (if any)	Health Care provider (name and address)

XII. Out-of-Pocket Losses or Expenses

A. If you are making a claim for out-of-pocket losses other than gambling losses and associated losses (fees, etc.) , please describe the following:

1. Nature of losses or expenses (including amount claimed, when and where each loss occurred, gambling type/game): _____

2. The date that you first became aware of the losses or expenses: _____

3. How you first became aware of the losses or expenses: _____

4. Whether those losses or expenses are continuing: _____

[Please attach additional pages as necessary.]

B. If you are making a claim for gambling losses, please answer the following:

1. When did you first begin gambling after taking Mirapex?
2. How often did you gamble while on Mirapex?
3. What games did you play (what did you bet on)?
4. Where did you gamble while taking Mirapex, including names and addresses of casinos and other locations?
5. Are you still gambling (yes/no)?
6. When was the last time you gambled (date)?

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C. Have you ever won more than \$1,000 through a bet or during a gambling session?

_____ Yes _____ No _____ I don't know

If "Yes," please complete the following for each session:

- a. Location (website or name and physical address of casino): _____
- b. Date of session: _____
- c. Type of wager or game played: _____
- d. Amount of winnings: _____

[Please attach additional pages if necessary.]

D. Do you have an accountant or tax preparer? _____ Yes _____ No

(Please provide name(s) and address(es)): _____

XIII. Witnesses

Are there persons (other than those already identified in this Fact Sheet) whom you believe are witnesses to your claimed injuries or damages? If yes, please provide their name(s) and address(es):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

XIV. Discussions With Healthcare Providers

Have you had any discussions with any healthcare provider about whether Mirapex contributed to your physical injuries, emotional distress, psychological injuries, out-of-pocket losses, or illness? _____ Yes _____ No

If "Yes," provide the healthcare provider's name and address, the date of that discussion, and state the general substance of the discussion: _____

XV. Documents

Please provide a copy of all of your documents and things which fall into the categories listed below. This includes documents and things in your personal possession, as well as items being held for you by another person, including your lawyer or any relative.

- 1. A copy of all records (including psychiatric or psychological records) from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions, in the last ten (10) years.
- 2. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

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3. If you have been the claimant or subject of any other lawsuit or claim relating to your health, mental or physical condition, all documents relating to such lawsuit or claim (except documents protected under the attorney-client privilege or work product doctrine).
4. All instructions, product warnings, package inserts, advertising materials, pamphlets, magazine or newspaper articles, internet information, promotional materials, any documents or materials from Defendants, or pharmacy handouts that you have regarding Mirapex.
5. All letters, e-mails, or other written communications between you and the Defendants.
6. Copies of the entire packaging, including the bottle, box and label for the Mirapex you allege caused you injury and any remaining medication.
7. If you are claiming gambling losses, lost wages or lost earning capacity:
 - a. Copies of your federal tax returns for each of the last ten (10) years.
 - b. Copies of credit card statements, bank statements, and other personal financial records that reflect your claimed damages
 - c. For gambling losses, all documents relating specifically to gambling activity (such as "player's club" statements, W2-Gs, and other correspondence from casinos, all records relating to online gambling, and records of wagers placed with bookmakers).
8. If you claim any loss from medical expenses, copies of all bills for which you are seeking reimbursement from any physician, hospital, pharmacy or other health care provider.
9. Copies of letters testamentary or letters of administration relating to your status as Plaintiff.
10. Decedent's death certificate (if applicable).
11. All records you kept relating to your use of medications during the time you were taking Mirapex.
12. A copy of all documents relating to you or your spouse filing or petitioning for bankruptcy (if applicable).
13. A copy of all documents relating to you or your spouse filing or petitioning for separation, divorce or dissolution of marriage.
14. All personal net worth statements and financial loan applications made by or on behalf of you over the past 10 years.
15. All Freedom of Information Act requests and responses relating to Mirapex or the allegations involved in this case.

XVI. Authorizations

Please complete and sign the attached Authorization for Release of Medical Records, attached Authorization for Release of Employment and Unemployment Records, attached

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Authorization for Release of Tax Returns and Records, and attached Authorization for Release of Gambling Related Records and Accounts from Foreign Nations and Countries.

If you have filed a Workers' Compensation or Social Security disability claim, please complete and sign the attached Authorization for Release of Workers' Compensation and Social Security Records.

XVII. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part XV. of this Plaintiff's Fact Sheet and, as required above.

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

Dated

Signature

Privileged and Confidential: Attorney-Work Product

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

IN RE: MINNESOTA DISTRICT COURT
MIRAPEX® PRODUCT LIABILITY LITIGATION

AUTHORIZATION FOR RELEASE OF
WORKERS' COMPENSATION AND SOCIAL SECURITY RECORDS

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all workers' compensation and social security records of any sort, including but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, concerning

Name of Claimant

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of Defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records. This authorization shall expire two (2) years after the date it is expected.

Name of Representative

Representative Capacity (e.g., attorney, records requester, agent, etc.)

Street Address

City, State and Zip Code

Privileged and Confidential: Attorney-Work Product

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through as original had been presented to you.

Date: _____

Claimant or Guardian Signature

Date: _____

Witness Signature

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff Fact Sheet, the attorney for the plaintiff/decedent named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

Privileged and Confidential: Attorney-Work Product

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

IN RE: MINNESOTA DISTRICT COURT
MIRAPEX® PRODUCT LIABILITY LITIGATION

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all medical records, including, but not limited to, medical reports, blood tests, radiographic films, CT scans, X-rays, MRI films, MRA films, correspondence, progress notes, prescription records, echocardiographic recordings, written statements, employment records, wage records, disability records, medical bills, and other documents in your possession, including records for treatment of psychological, psychiatric or emotional problems, concerning

Name of Patient

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of Defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records. This authorization shall expire two (2) years after the date it is executed.

Name of Representative

Representative Capacity (e.g., attorney, records requester, agent, etc.)

Street Address

Privileged and Confidential: Attorney-Work Product

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization. Conversations by the bearer of this authorization with health care providers, however, are not authorized by this release form.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through as original had been presented to you.

Date: _____

Patient of Guardian Signature

Date: _____

Witness Signature

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the plaintiff/decedent named in the foregoing medical authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff's Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

Privileged and Confidential: Attorney-Work Product

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

IN RE: MINNESOTA DISTRICT COURT
MIRAPEX® PRODUCT LIABILITY LITIGATION

AUTHORIZATION FOR RELEASE OF EMPLOYMENT
AND UNEMPLOYMENT RECORDS

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of all applications for employment, resumes, records of all positions held, job descriptions of positions held, salary and/or compensation records, performance evaluations and reports, statements and comments of fellow employees, attendance records, W-2's, workers' compensation files; all hospital, physician, clinic, infirmary, psychiatric, nurse and dental records, x-rays, test results, physical examination records; any records pertaining to claims made relating to health, disability or accidents in which I was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf, and any other records relating to my employment with the above-named institution, including records for treatment of psychological, psychiatric or emotional problems, concerning

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of Defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative
1
Ex. "C"

Privileged and Confidential: Attorney-Work Product

Representative Capacity (e.g., attorney, records requester, agent, etc.)

Street Address

City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone. This authorization shall expire two (2) years after the date it is executed.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through as original had been presented to you.

Date: _____

Patient of Guardian Signature

Date: _____

Witness Signature

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the plaintiff/decedent named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff’s Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the patient named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.

Privileged and Confidential: Attorney-Work Product

Form **4506**

Request for Copy of Tax Return

Rev. April 2006
Department of the Treasury
Internal Revenue Service

- ▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.
- ▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0420

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

<p>1a Name shown on tax return. If a joint return, enter the name shown first.</p>	<p>1b First social security number on tax return or employer identification number (see instructions)</p>
<p>2a If a joint return, enter spouse's name shown on tax return</p>	<p>2b Second social security number if joint tax return</p>
<p>3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code</p>	
<p>4 Previous address shown on the last return filed if different from line 3</p>	
<p>5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.</p>	

Caution: If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.

6 Tax returns requested (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form 990, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. **Note:** If the copies must be certified for court or administrative proceedings, check here.

7 Year or period requested. Enter the ending date of the year or period, using the month/day format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 Fee. There is a \$30 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	\$ 30.00
b Number of returns requested on line 7	
c Total cost. Multiply line 8a by line 8b	\$

9 If we cannot find the tax return, we will refund the fee, if the refund should go to the third party listed on line 5, check here.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, executor, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Signature (see instructions)	Date	Enter home number of taxpayer on line 1a or 2a ()
Title (if line 1a above is a corporation, partnership, estate, or trust)		
Spouse's Signature	Date	

Privileged and Confidential: Attorney-Work Product

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

IN RE: MINNESOTA DISTRICT COURT
MIRAPEX® PRODUCT LIABILITY LITIGATION

AUTHORIZATION FOR RELEASE OF
GAMBLING RELATED RECORDS AND ACCOUNTS
FROM FOREIGN NATIONS AND COUNTRIES
(INCLUDING NATIVE AMERICAN NATIONS)

To: _____
Name

Address

City, State and Zip Code

This will authorize you to furnish copies of any and all gambling related records and accounts of any sort, including, but not limited to players' club accounts, lines of credit, statements, disclosures, correspondence, notes, contracts or other documents concerning

Name of Claimant
whose date of birth is _____ and whose social security number
is _____.

You are authorized to release the above records to the following representatives of Defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Name of Representative

Representative Capacity (e.g., attorney, records requester, agent, etc.)

Street Address

City, State and Zip Code

Privileged and Confidential: Attorney-Work Product

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization is not valid unless the record requester named above has executed the acknowledgement at the bottom of this authorization. This authorization shall expire two (2) years after the date it is executed.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through as original had been presented to you.

Date: _____
_____ Claimant or Guardian Signature

Date: _____
_____ Witness Signature

ACKNOWLEDGEMENT

The undersigned, as the record requester named in the above tax return and tax records authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the person named in the foregoing authorization has been given notice that the authorization will be used to request records from the person or entity to whom it is addressed, if named in Plaintiff’s Fact sheet; or, if the authorization is addressed to a third party not listed in Plaintiff Fact Sheet, the attorney for the patient named has been given ten (10) days advance notice and has been afforded an opportunity to object to the request, and any objections have been resolved. The attorney for the person named in the foregoing authorization has also been afforded an opportunity to order copies of the records from the undersigned requestor at a reasonable cost.
