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2 **DISTRICT COURT**
3 **CLARK COUNTY, NEVADA**
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6 **In the Matter of Endoscopy Center and**
7 **Associated Businesses**

Case No. **A558091**

Dept. **XIX**

8 **ELECTRONIC FILING CASE**
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11 **FACT SHEET FOR NON-INFECTED PLAINTIFFS**

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13 Please provide the following information for each individual on whose behalf a claim is
14 being made. In filling out this form, please use the following definitions: (1) "health care
15 provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic
16 laboratory, or other facility that provides medical, dietary, psychiatric, mental, emotional or
17 psychological care or advice, and any pharmacy, drug counseling, substance abuse facility,
18 counselor, dentist, x-ray department, laboratory, physical therapist or physical therapy
19 department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor,
20 psychologist, therapist, nurse, herbalist, nutritionist, dietician, or other persons or entities involved
21 in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or
22 record of every type that is in your possession or the possession of your counsel, including but not
23 limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs
24 or tapes, and x-rays, drawings, graphs, phono-records, nonidentical copies and other data
25 compilations from which information can be obtained and translated, if necessary, by the
26 respondent through electronic devices into reasonably usable form. You may attach as many
27 sheets of paper as necessary to fully answer these questions. If you have any documents (as
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defined above), including, but not limited to, tests for Hepatitis C, Hepatitis B or HIV, including without limitation, anti-HCV tests, HCV RIBA tests, HCV-RNA tests, viral load or quantitative HCV tests, viral genotyping, heptatitis B surface antibody (anti-HBs) tests, hepatitits B surface antigen (HBsAg) tests, hepatitis B e-antigen (HBeAg) tests, anti-HBe tests, anti-hepatitits B core antigen (anti-HBc) tests, HBV DNA tests, Home Access HIV-1 Tests, EIA (enzyme immunoassay) blood tests for HIV antibodies, oral fluid tests for HIV antibodies, urine tests for HIV antibodies, RNA tests for genetic material of HIV or any other tests for these diseases, you must NOT dispose of, alter or modify these documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations please contact your attorney.

I. CASE INFORMATION

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

1. Case Caption:

2. Civil Action No. in Eighth Judicial District Court:

3. Please state name, address, telephone number, fax number and e-mail address of principal attorney representing you.

Attorney Name

Firm

Street Address

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City, State and Zip Code

Telephone number Fax Number

E-mail address

B. Claim Information

1. Do you claim that any physical, psychiatric, psychological or emotional injuries, illnesses and/or conditions have resulted from your being treated at an endoscopic ambulatory surgery center? Circle [Yes or No]

2. If the answer to the foregoing question is yes, state the nature of the injuries, illnesses or conditions.

C. Identify the place where you had your treatment:

D. State the dates that you went to the treatment facility:

E. State the name of the physician that treated you endoscopically:

F. State whether you had any of the following treatments:

1. Colonoscopy
2. Upper gastrointestinal endoscopy
3. Sigmoidoscopy
4. EUS (Endoscopic Ultrasound)
5. Esophageal 24-hour pH study
6. Esophageal and anorectal manometry
7. ERCP (Endoscopic Retrograde Cholangio-Pancreatography)
8. Capsule endoscopy
9. EGD (esophagogastroduedenoscopy)
10. Esophageal dilation
11. Flexible sigmoidoscopy
12. PEG (Percutaneous endoscopic gastrostomy tube) G-tube insertion/replacement/removal
13. Polypectomy
14. Dilation

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15. Brand pH study
16. Other, please specify

G. Whether you were anesthetized or sedated for the above procedure (s): Circle (Yes/No)

H. The name of the anesthesiologist or nurse anesthestist (CRNA) who sedated you:

II. PERSONAL INFORMATION

A. Last Name:

B. First Name:

C. Middle Name or Initial:

D. Maiden or other names used or by which you have been known, and the dates during which you were known by such names:

E. Present Street Address:

F. Date of Birth:

G. Sex: Circle (Male/Female)

III. FAMILY INFORMATION

A. Has anyone you have ever been married to been diagnosed with Hepatitis or HIV or AIDS?

IV. MEDICAL BACKGROUND

A. To the best of your knowledge, have you engaged in any of the following activities during the past fifteen (15) years:

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2 1. Receiving an injection not prescribed by a physician or other licensed health care provider? Circle (Yes/No)
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4 2. Receiving organs from donors or undergoing an organ transplant? Circle (Yes/No) If yes, please state the date or dates.
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6 3. As a health care worker, getting pricked by a needle with possible infected blood? Circle (Yes/No)
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8 4. Exposure to blood products for treatment of hemophilia or chronic kidney failure? Circle (Yes/No) If yes, please state the date or dates.
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10 5. Getting a tattoo or body piercing? Circle (Yes/No)
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12 6. Sexual relations with a person infected with Hepatitis B or C or HIV or AIDS? Circle (Yes/No)
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14 7. Received a blood transfusion? Circle (Yes/No) If yes, please state the date or dates.
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16 8. Being incarcerated in a state or federal prison? Circle (Yes/No)
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18 9. Any operation, surgical procedure or hospitalization prior to 1992? Circle (Yes/No) If so, was it outside the United States? Circle (Yes/No) If yes, identify the country (ies):
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22 10. Underwent any dialysis? Circle (Yes/No)
11. Were notified that you received blood from a donor who later tested positive for Hepatitis C? Circle (Yes/No)
23 12. Have ever been on long-term kidney dialysis? Circle (Yes/No)
24 13. Have evidence of liver disease (e.g., persistently abnormal ALT levels)? Circle (Yes/No)
25 14. Received acupuncture treatment?
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27 B. Have you ever received an injection, or venous or arterial access treatment, within the last fifteen (15) years? Circle (Yes/No)
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If you circled Yes, please state:

1. The country or countries in which you received that treatment;

2. The date or dates of that treatment;

3. A description of the treatment or care you received;

4. Whether you were hospitalized for medical treatment and, if so, the name and address of the hospital.

C. If you claim psychological, cognitive or emotional injury as a consequence of being notified that you might have been exposed to hepatitis B, hepatitis C or HIV as a result of being sedated or anesthetized at an endoscopy treatment center, state whether you have experienced or been treated for any psychological, psychiatric (including depression) or emotional problem prior to this notification? Circle (Yes/No)

1. If yes, please state:

2. Name and address of each person who treated you:

a) Name

b) Street Address (if not otherwise provided)

3. Condition for which treated

4. When treated

V. DAMAGE CLAIMS

A. Have you been tested for Hepatitis C, Hepatitis B, or HIV since February 2004? Circle (Yes/No)

B. If your answer to the preceding question is "no," state:

1. Whether you intend to have such testing done:

2. When and where such testing is anticipated to occur:

3. The anticipated cost of such testing and the source of such estimate:

C. If the answer to A., above, is "yes," state:

1. Whether such testing was prescribed by any health care provider and, if so, by whom:

2. Whether you intent to be tested again in the future for Hepatitis C, Hepatitis B, or HIV, and if so, when you anticipate such testing will occur, and your estimate of the cost of such testing:

3. Whether future testing for Hepatitis C, Hepatitis B, or HIV has been prescribed for you by any healthcare provider, and if so, the identity of such healthcare provider:

VI. DOCUMENTS

A. Please attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

1. A copy of any notice you received regarding possible risk of contracting hepatitis B, hepatitis C or HIV at the facilities of any Defendant.

2. A copy of all medical records from any physician, hospital or health care provider, who treated you at any time for hepatitis B, hepatitis C, HIV or any other disorder (physical or mental) arising from your care and treatment at an endoscopic treatment center, or who recommended testing due to a potential exposure at an endoscopic treatment center.

B. All diagnostic tests or test results including, tests for Hepatitis C, Hepatitis B or HIV, including without limitation, anti-HCV tests, HCV RIBA tests, HCV-RNA tests, viral

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VII. IDENTIFICATION OF HEALTH CARE PROVIDERS

A. If you have been tested positive for Hepatitis B, Hepatitis C or HIV/AIDS, please identify your treating physician:

1. Name:
2. Address:
3. Specialty:

[CONTINUED ON NEXT PAGE]

B. Please identify your primary care physician at present:

1. Name:
2. Address:
3. Specialty:

DECLARATION

I declare under penalty of perjury that all of the information provided in this Fact Sheet for Non-infected Plaintiffs is true and correct to the best of my knowledge, information and belief.

Dated this ____ day of _______, 2008

____

Signature

Print name of Plaintiff:

[ATTACH ADDITIONAL SHEETS, IF NECESSARY TO COMPLETE EACH SUBSECTION]