3. DEVICE INFORMATION - ADDITIONAL DEVICE

Name of Bard Implanted Port Catheter Product ("Device"):

_____

Model Number/Product Code: _____

Lot Number: _____

Date of implant:_____

Provide the medical record, your medical alert card, or other documentation showing your Device Product Code and Lot Number.

- ☐ **Medical records attached**
- ☐ **Medical alert card attached**
- ☐ **Other documentation showing Product Code and Lot Number attached**

Please check all the reasons why you believe your Device was implanted:

- ☐ **Blood draws**
- ☐ **Blood transfusions**
- ☐ **Chemotherapy delivery**
- ☐ **Immunotherapy delivery**
- ☐ **IV fluid delivery**
- ☐ **IV antibiotics**
- ☐ **Parenteral nutrition**
- ☐ **Other – please describe below:**

_____

Provide the name and address of the doctor who implanted the Device and the hospital/medical facility at which the Device was implanted:

Doctor: _____

Hospital/Medical Facility:

_____

Provide medical records for the implant of the Device.

- ☐ **Medical Records attached**

***NOTE: If you are alleging injuries related to more than one Device, complete Sections 3-8 for each Device and attach additional pages as needed.**

4. FAILURE MODE ALLEGED

Please check all failure mode(s) that you allege apply to the Device and attach medical records that show the failure mode:

CATHETER-RELATED FAILURE MODES:

☐ **Catheter-related infection**

Type of infection: _____

☐ **Thrombosis in or around catheter**

☐ **Occlusion of the catheter**

☐ **Fracture of catheter without migration of a fragment**

☐ **Fracture of catheter with migration of a fragment to _____(state location in your body)**

☐ **Other – state in detail:**

_____

☐ **None (not making a catheter-related claim)**

For each catheter-related complication identified above, state the date you were first diagnosed with such complication and state the name of the medical provider who diagnosed and/or treated the complication:

_____

For each catheter-related complication identified above, provide medical records relating to the first diagnosis of each complication.

☐ **Medical records attached**

PORT-BODY/RESERVOIR-RELATED FAILURE MODES:

☐ **Port-body/reservoir-related infection**

Type of infection: _____

☐ **Thrombosis of port body/reservoir**

☐ **Occlusion of port body/reservoir**

☐ **Erosion or wound complications at the port-body site**

☐ **Other – state in detail: _____**

☐ **None (not making a port-body/reservoir-related claim)**

For each port-body/reservoir-related complication identified above, state the date you were first diagnosed with such complication and state the name of the medical provider who diagnosed and/or treated the complication:

_____

For each port-body/reservoir-related complication identified above, provide medical records relating to the first diagnosis of each complication.

☐ **Medical records attached**

5. REMOVAL INFORMATION

*** This Section is limited to removal of the Device as a whole. Information regarding fractures and removal of fracture remnants should be provided in Section 7.**

Has your Device identified in Section 3 been removed?

☐ **Yes** ☐ **No**

If yes, provide the name(s) and address(es) of the doctor(s) who removed your Device and the hospital/medical facility where the removal/attempted removal occurred:

Doctor:

_____

Hospital/Medical Facility:

_____

Date of removal: _____

Provide medical records for the removal/attempted removal and the procedure involved.

☐ **Medical records attached**

Was the Device identified in Section 3 preserved after removal?

☐ **Yes** ☐ **No**

If yes, state the name and address of the person or institution in possession of the Device: _____

Do you have photographs and/or video of the removed Device or of the removal procedure?

☐ **Yes photographs. If yes, produce color copies of the photos.**

☐ **Photographs attached**

☐ **Yes video. If yes, retain the video.**

☐ **No**

6. SUBSEQUENT DEVICE

If your Device identified in Section 3 was removed, was a subsequent device implanted?

☐ **No**

☐ **Yes. State date of implant of replacement device: _____**

Was it replaced with a Bard Port Catheter Device? If yes, provide:

Product Name: _____

Product Code: _____ Lot Number: _____

If no, provide the name of replacement device: _____

7. CATHETER FRAGMENTS

Do you claim that the catheter of your Device fractured?

☐ **Yes**

☐ **No**

If you answered YES, answer the below questions in this Section.

If you answered NO, skip the rest of Section 7 and go below to Section 8 - "Outcome Attributed to Device."

Are any catheter fragments retained in your body?

☐ **Yes**

☐ **No**

☐ **Unknown**

If yes, identify the location(s) within your body of each retained catheter fragment.

_____

Have any catheter fragments been removed from your body?

☐ **Yes**

☐ **No**

☐ **Unknown**

If any catheter fragment has been removed (or a doctor has attempted to remove it), please check all that apply regarding the removal procedure(s):

- ☐ **Removed percutaneously**
- ☐ **Removed via open-chest procedure**
- ☐ **Removed via alternative open procedure**
- ☐ **Attempted but unsuccessful removal percutaneously**
- ☐ **Attempted but unsuccessful removal via open-chest procedure**
- ☐ **Attempted but unsuccessful removal via alternative open procedure**

If any catheter fragment has been removed or if there has been an attempt to remove, state the following for each removal/attempt:

Doctor: _____

Hospital/Medical Facility: _____

Date: _____

Doctor: _____

Hospital/Medical Facility: _____

Date: _____

Doctor: _____

Hospital/Medical Facility: _____

Date: _____

Provide medical records that provide the date(s) of removal (or attempted removal), the location (in your body) of the fractured fragments, and the procedure(s) performed to remove (or attempt to remove) the fragments.

- ☐ **Medical records attached**

Do you have photographs and/or video of the removed Device or fragments or of the removal procedure?

- ☐ **Yes photographs. If yes, produce color copies of the photos.**
- ☐ **Photographs attached**
- ☐ **Yes video. If yes, retain the video.**
- ☐ **No**

8. OUTCOME ATTRIBUTED TO DEVICE

Do you claim that you suffered or that you are currently suffering from any bodily injuries, including psychological injuries related to the Device identified in Section 3:

- ☐ **Yes**
- ☐ **No**

If your answer is "Yes," please list all symptoms and injuries you claim to have suffered and describe the medical treatment received to address them:

_____

Of the injuries/symptoms you listed above, which do you claim to be suffering from at the current time:

_____