

PRIMARY CLASS MEMBERS' QUESTIONNAIRE
Dupont Class Action

If you believe you fall into the Primary Class (being “all persons resident in Canada who were implanted by the Defendants with a foot stent not approved by Health Canada”) and wish to participate in the settlement of this class proceeding, **please complete and submit this questionnaire with supporting documentation to the address below by December 11, 2019**. Prior to completing this Questionnaire, please ensure you have carefully read the Notice of Certification and Settlement Approval Motion and the Notice of Settlement.

PERSONAL INFORMATION

1. Name: _____
2. Date of birth: _____
3. Current address: _____

PRE-INJURY HEALTH

4. Prior to the stent insertion surgery what problems did you have with your feet? Please provide the following information:

| | Problem #1 | Problem #2 | Problem #3 | Problem #4 | Problem #5 |
|--|------------|------------|------------|------------|------------|
| Nature of the problem | | | | | |
| When did the problem start? | | | | | |
| What limitations did you have arising out of these problems? | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| What treatment did you receive for these problems prior to seeing Mr. Dupont? | | | | | |
|---|--|--|--|--|--|

5. What benefits of the stent insertion procedure were discussed with you by Mr. Dupont?

6. What risks of the stent insertion procedure were discussed with you by Mr. Dupont?

7. Did Mr. Dupont discuss alternatives to the stent insertion procedure with you? If yes, what did you discuss?

8. Did you consult with any other medical professional with respect to the decision to undergo the stent insertion procedure? If yes, provide their name and particulars of any advice you received.

THE PROCEDURE

9. What date did the right foot stent insertion procedure occur on?

10. What date did the left foot stent insertion procedure occur on?

11. Which foot stent(s) were confirmed to be fake stents (*not* HyProCure© stents)? Please attach any documentation received that confirms your foot stent(s) were/are fake.

12. Did your symptoms change following the procedure(s)? If yes, explain how.

a. Changes in your **right foot**:

b. Changes in your **left foot**:

13. During your recovery from the stent insertion procedures...

a. What were you **not** able to do that you could do before?

b. What assistance did you need at home?

c. Was there any cost associated with the assistance received? If yes, what were the specifics of the expenses incurred (e.g. how much, for how long)?

d. Who provided this assistance?

e. Did you require the use of any equipment (i.e. crutches, cane, grab bars, orthotics, etc.) following the stent insertion? If yes, provide the following:

| | Equipment #1 | Equipment #2 | Equipment #3 | Equipment #4 | Equipment #5 |
|---|--------------|--------------|--------------|--------------|--------------|
| Type of equipment | | | | | |
| How long did you use the equipment? | | | | | |
| How much was the cost of the equipment? | | | | | |

14. Please provide the following information regarding any impacts alleged to be caused by the stent insertion:

| | Psychological Impacts | Physical Impacts |
|---|------------------------------|-------------------------|
| List impacts suffered | | |
| Type of treatment(s) received | | |
| How long were you treated | | |
| Is there a need for on-going and/or future treatment? | | |

15. Since the stent insertion procedure, did you require any treatment or therapy? If yes, please provide the following information:

| | Therapy #1 | Therapy #2 | Therapy #3 | Therapy #4 | Therapy #5 |
|--|------------|------------|------------|------------|------------|
| Type of therapy or treatment accessed | | | | | |
| Name and contact information of treatment provider | | | | | |
| Dates you received therapy or treatment | | | | | |
| Cost of attending this therapy or treatment | | | | | |

16. Since the stent insertion procedure, have you had any further surgery with respect to the stent insertion (including removal of the stents)? If yes, please provide the following information:

| | Surgery #1 | Surgery #2 | Surgery #3 | Surgery #4 |
|---------------------------------|------------|------------|------------|------------|
| What was the surgery performed? | | | | |
| Who performed the surgery? | | | | |
| When was the surgery performed? | | | | |

| | | | | |
|-----------------------------------|--|--|--|--|
| What was the cost of the surgery? | | | | |
|-----------------------------------|--|--|--|--|

COST OF FUTURE CARE

17. What equipment do you require currently as a result of your stent-related injuries and impairments?

18. What medications are you currently using that are related to the stent insertion and/or removal procedure?

19. What treatment, therapy and services do you require as of this date that is related to the stent insertion and/or removal procedure, for example: physiotherapy, occupational therapy, massage therapy, doctors?

20. Who pays for your equipment, medication and/or therapies currently?

21. What is the cost of your equipment, medication and/or therapies as of this date? (Please provide a clear breakdown of what each costs per month or per year and ensure you have supporting documentation).

22. If you have an extended health care plan that has paid for any treatment, equipment or services related to the stent insertion and/or removal procedures, please provide those details.

23. Has any of your medical treatment related to the stent insertion and/or removal procedure(s) been covered by provincially funded healthcare (for example, OHIP)? If yes, please list what treatment was covered.

24. If you are not using any equipment, taking any medications or receiving any treatment/therapies, has a doctor or treatment provider informed you that you will need any of the above in the future? If yes, please provide written confirmation from your treatment provider.

POST-STENT PROCEDURE RESTRICTIONS

25. Has your ability to drive changed since the stent insertion procedure? If yes, how so?

26. Has your ability to do housekeeping and home maintenance tasks changed since the stent insertion procedure? If yes, how so?

27. Has your ability to perform child care responsibilities changed since the stent insertion procedure? If yes, how so?

28. Have there been any changes to your family life since the stent insertion procedure? If yes, how so?

29. Have there been any changes to your social and/or recreational life since the stent insertion procedure? If yes, how so?

30. Have you had to change or cancel any vacations as a result of the stent insertion procedure?

Is wage loss/loss of capacity/loss of capital asset alleged? If no, then skip to question #40.

PRE-TREATMENT INCOME

31. Provide the following work history from **two years prior** to the stent insertion procedure to present if your employment is wage based:

| | Job #1 | Job #2 | Job #3 | Job #4 |
|-------------------------------------|--------|--------|--------|--------|
| Job title | | | | |
| Dates employed | | | | |
| Wage | | | | |
| Hours per week | | | | |
| Employment tasks & responsibilities | | | | |

32. Did you have any plans to change jobs or retire before the stent insertion procedure? _____

a. Have these plans changed? If yes, how so?

33. If you are a *business owner* claiming wage loss, please provide the following information:

a. When did you start your business? _____

b. What type of business is it? _____

c. Are you incorporated? If yes, what is the corporation's name?

d. Do you have any business partners? _____

e. How are you paid? _____

f. If you have any other sources of income, please provide details.

POST-STENT INCOME LOSS

34. Provide the particulars of your income loss claim to date, including the following:

a. From which dates were you unable to work?

b. What was the total amount of income you lost for this period of time?

c. Attach supporting documentation (i.e. income tax returns showing a decrease in your salary, pay stubs showing a decrease in your wages/salary or a letter from your employer).

35. Why were you unable to work during this time?

36. Did a physician or other medical professional tell you not to work? If yes, please provide the following information:

a. Full name: _____

b. How long were you advised not to work for? _____

37. Have you returned to work? If yes, on what date? _____

38. Provide details of any job search and retraining undertaken as a result of the stent insertion/removal procedure.

39. Are you claiming for any loss of seniority or promotion? If yes, please provide details.

SPECIAL DAMAGES

40. Provide details and receipts and/or proof of payment for the following expenses related to the stent insertion and/or removal procedure(s) and your injuries and impairments relating therefrom:

a. Out-of-pocket money spent on medical bills, including the stent procedure(s);

b. Out-of-pocket money spent on equipment;

c. Out-of-pocket money spent on medication;

d. Out-of-pocket money spent on property modification;

e. Out-of-pocket money spent on treatment and therapies;

- f. Out-of-pocket money spent on travel related to the stent procedure(s) and/or related treatment; and,

- g. Any other out-of-pocket expenses incurred as a result of the stent insertion and/or removal procedure(s)

DOCUMENTS TO ATTACH:

1. Confirmation that your foot stent(s) were fake;
2. Confirmation that you received the medical treatment, therapy, equipment and/or medication as listed above (either by proof of payment or medical records);
3. Confirmation that you were unable to work as a result of the stent insertion and/or removal procedure(s) if you are claiming income loss;
4. Income tax returns for 3 years prior to the stent insertion procedure to present (or pay stubs) if you are claiming income loss; and,
5. The receipts and/or proof of payment for the expenses listed above in question 40.

It is important that you include the supporting documentation requested above so that Class Counsel can properly assess the compensation you are entitled to. Your damages will be assessed by Class Counsel based on the information contained within this Questionnaire. If any Primary Class Member disagrees with Class Counsel's assessment of their damages claim, the Class Member will have the option of appealing their claim to the Administrator appointed by January 20, 2020.

Individuals who qualify as Class Members and who wish to participate in the Class Action are automatically included in the Class Action. Any Class Member who wishes to

opt out of the Class Action may do so on or before December 11, 2019. **By completing this Questionnaire, it is assumed that you will not opt out of the Class Action.**

Please submit your completed Questionnaire by email to Lucy Jackson at ljackson@thomsonrogers.com

Questions for counsel from Class Members should be directed by email, fax or telephone to:

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Toronto, Ontario, M5H 1W2
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