IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

IN RE: ABBOTT LABORATORIES, ET AL., PRETERM INFANT NUTRITION PRODUCTS LIABILITY LITIGATION	**MDL NO. 3026** **Master Docket No. 1:22-cv-00071**
This Document Relates to: **ALL CASES**	**Hon. Rebecca R. Pallmeyer**

CASE MANAGEMENT ORDER NO. 10
APPROVING PLAINTIFF FACT SHEET

In furtherance of the effective and efficient case management of this complex litigation, this Case Management Order ("CMO") will authorize the form of the Plaintiff Fact Sheet ("PFS") to be completed by each plaintiff selected as an Initial Bellwether Discovery Case. This CMO is binding on all parties and their counsel involved in this multi-district litigation. It is **ORDERED** as follows:

1. The parties have agreed to the entry of the Plaintiff Fact Sheet ("PFS"), attached here as **Exhibit A.**

2. Each plaintiff selected as an Initial Bellwether Discovery Case shall complete a PFS and serve to Defendants within 30 days of the date on which the Court enters an Order pursuant to CMO 7 identifying that case as an Initial Bellwether Discovery Case.

IT IS SO ORDERED.

Dated: November 3, 2022

Hon. Rebecca R. Pallmeyer
Chief Judge

EXHIBIT A

PLAINTIFF FACT SHEET

This Fact Sheet must be completed by each plaintiff whose case is selected for inclusion in the MDL 3026 Initial Bellwether Discovery Cases. The Fact Sheet should be completed to the best of each plaintiff's recollection and ability at that time. If the information responsive to any question is contained in medical records or other documents that have been, or are being produced to Defendants with this Fact Sheet, identifying the documents containing the responsive information is a sufficient response to each such question. If the response to any question is that the person completing this Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location. Please do not leave any questions unanswered or blank. Further, where necessary, each plaintiff or his or her representative should attach additional pages to respond fully to each question and/or request. You must seasonably supplement or amend your responses if you learn that they are incomplete or incorrect in any material respect.

In filling out this form please use the following definition:

"Healthcare Provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides or purports to provide medical, dietary, psychiatric, mental, emotional or psychological care or advice, and any physician, pharmacist, practitioner of the healing arts, psychiatrist, psychologist, therapist, pharmacy, counselor, dentist, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, nurse, herbalist, nutritionist, dietician or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of the Infant who consumed infant formula or fortifier product.

"Infant" refers to the individual who has consumed an infant formula or fortifier product and was injured by necrotizing enterocolitis, as alleged in the plaintiff's complaint. Questions below are not limited to the time period when Infant consumed the infant formula or fortifier product at issue, if the Infant is alive.

I. CASE INFORMATION

A. Case Caption and Number: _____

_____

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. Your Name: _____
2. Street Address: _____
3. City, State, Zip: _____
4. In what capacity are you representing the individual: _____

_____

5. If you were appointed by a court, state the:

   a) Court: _____

   b) Date of Appointment: _____

6. Your relationship to the deceased or represented person: _____

_____

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

_____

II. PERSONAL INFORMATION: FORMULA OR FORTIFIER-CONSUMING INFANT

A. Full Name: _____

B. Date of Birth: _____

C. Hospital of Birth: _____

D. Home Address at Date of Birth: _____

_____

E. For the one-year period prior to the date of completing this PFS, provide the home address(es):

_____

_____

F. Social Security Number: _____

G. Medicare/Medicaid Identifier: _____

H. Current Occupation: _____

I. Current Employer: _____

III. CLAIM INFORMATION

A. Date of diagnosis of Necrotizing Enterocolitis: _____

B. Was this diagnosis made while the Infant was admitted in a Neonatal Intensive Care Unit?

___ YES ___ NO ___ OTHER

If YES, please state the name and address of the Neonatal Intensive Care Unit (NICU) and, if known, the name of any healthcare provider(s) who diagnosed the Infant with Necrotizing Enterocolitis below. If OTHER, please explain below.

_____

_____

_____

_____

C. At the time of diagnosis, did any healthcare provider state an opinion regarding the cause of the Necrotizing Enterocolitis?

___ YES ___ NO ___ OTHER

If YES, please state the name and address of the healthcare provider and describe the opinion expressed below. If OTHER, please explain below.

_____

_____

_____

_____

D. Describe the Infant's current medical condition, including any ongoing physical or psychological conditions allegedly caused by Necrotizing Enterocolitis ("NEC").

_____

_____

_____

_____

E. Before the filing of your lawsuit, have any of the Infant's healthcare providers ever stated that the Infant's claimed injuries were caused by infant formula or fortifier products?

___ YES ___ NO ___ OTHER

If YES, please state the name and address of the healthcare provider and approximate date statement was made below. If OTHER, please explain below.

_____

_____

_____

_____

F. Please provide the following information regarding the specific infant formula or fortifier product you allege caused the Infant's injury, if known.

Brand Name and Specific Formula or Fortifier Product Consumed by Infant	**Approximate Dates of Consumption**	**Approximate Dosage / Amount Consumed**	**Name of Healthcare Provider**

G. Did the Infant's parent(s)/guardian(s) receive any information or instructions regarding the infant formula or fortifier products at the time the above infant formula or fortifier products were administered?

___ YES ___ NO ___ OTHER

If YES, please describe the information or instructions provided and the name of the facility and the person(s) affiliated with the facility who provided the information or instructions below. If OTHER, please explain below.

_____

_____

_____

_____

_____

_____

H. Were any of the above identified infant formula or fortifier products administered by anyone other than a healthcare provider?

___ YES ___ NO ___ OTHER

If YES, please state the name of the person who administered the product, if known, the name of the product, the date of administration, the approximate dosage/amount administered, the date of purchase of the product, and name and address of the location of purchase of the product below. If OTHER, please explain below.

_____

_____

_____

_____

I. Did the Infant's parent/guardian ever purchase the above identified infant formula or fortifier products at retail or online stores?

___ YES ___ NO ___ OTHER

If YES, please state the name of the product, approximate dates of purchase, name and address of location of purchase, and from whom the purchase was made below. If OTHER, please explain below.

_____

_____

_____

_____

J. Did the Infant consume mother's own breast milk?

___ YES ___ NO ____ I DON'T KNOW/I DON'T RECALL

If NO, please explain why:

_____

_____

K. Was donor breast milk available at the Infant's NICU?

___ YES ____ NO ____ I DON'T KNOW/I DON'T RECALL

L. Did the Infant consume donor breast milk?

___ YES ___ NO ____ I DON'T KNOW/I DON'T RECALL

If YES, please identify the source of the donor milk:

_____

_____

M. To the extent not already produced, please produce the medical records of the Healthcare Providers and institutions identified in Section III and any other of the Infant's medical records collected by or provided to your attorneys that are in counsel's possession as of the date this PFS is executed.

IV. PERSONAL INFORMATION – PARENTS

Please complete the questions in Section IV with respect to the Mother and Father of the Infant who consumed the infant formula or fortifier product.

Mother

A. Full Name: _____

B. Date of Birth: _____

C. Home Address at Date of Infant's Birth: _____

_____

D. For the one-year period prior to the date of completing this PFS, provide the home address(es):

_____

_____

E. Social Security Number: _____

F. Medicare/Medicaid Identifier: _____

G. Current Occupation: _____

H. Current Employer: _____

I. During the past 10 years, has Mother been convicted of or pled guilty to a felony criminal charge? ___ YES ___ NO

If YES, please state the offense, the claim number (if any), the date of conviction or plea and whether the conviction has been expunged, and the court where the conviction or plea was entered:

_____

_____

_____

_____

J. Has Mother ever filed a Social Security or other disability claim relating to the Infant's alleged injury?

___ YES ___ NO

If YES, please state the year the claim was filed, where the claim was filed, claim/docket number (if applicable), nature of disability, period of disability, and outcome of claim:

_____

_____

_____

_____

K. Has Mother experienced a still birth?

___ YES ___ NO

If YES, please provide the following information:

Number of still births (please provide gestational age(s) at birth): _____

_____

L. Has Mother experienced a miscarriage?

___ YES ___ NO

If YES, please provide the following information:

Number of miscarriages: _____

M. Has Mother had other live births?

___ YES ___ NO

If YES, please provide the following information:

Number of other live births: _____ *For each pregnancy, including the pregnancy of the Infant named in Plaintiff's case, that ended in a live birth, please provide the following information:*

Date of Birth	**Gestational Age at Birth**	**Name of Child**	**Type of Delivery**
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean
			□ Vaginal Birth □ Planned/scheduled cesarean □ Emergency cesarean

For each child identified in Section IV.M above, please identify the following (attach additional pages if necessary):

Name of Child	**In the 3 months following birth, was the child administered any of the following (check all that apply):**	
	□ Parenteral feeding (intravenous administration of nutrients)	□ I do not know/recall
	□ Mother's own breastmilk	□ I do not know/recall
	□ Donor milk	□ I do not know/recall
	□ Infant formula product If yes, specify brand and product name(s) of formula, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall

If "I DO NOT KNOW/RECALL" checked for any of the above, please explain:

_____

_____

_____

_____

Name of Child	**In the 3 months following birth, was the child administered any of the following (check all that apply):**	
	□ Parenteral feeding (intravenous administration of nutrients)	□ I do not know/recall
	□ Mother's own breastmilk	□ I do not know/recall
	□ Donor milk	□ I do not know/recall

	□ Infant formula product If yes, specify brand and product name(s) of formula, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall

If "I DO NOT KNOW/RECALL" checked for any of the above, please explain:

_____

_____

_____

_____

Name of Child	**In the 3 months following birth, was the child administered any of the following (check all that apply):**

	□ Parenteral feeding (intravenous administration of nutrients)	□ I do not know/recall
	□ Mother's own breastmilk	□ I do not know/recall
	□ Donor milk	□ I do not know/recall
	□ Infant formula product If yes, specify brand and product name(s) of formula, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall

If "I DO NOT KNOW/RECALL" checked for any of the above, please explain:

_____

_____

_____

_____

Name of Child	**In the 3 months following birth, was the child administered any of the following (check all that apply):**	
	□ Parenteral feeding (intravenous administration of nutrients)	□ I do not know/recall
	□ Mother's own breastmilk	□ I do not know/recall
	□ Donor milk	□ I do not know/recall
	□ Infant formula product If yes, specify brand and product name(s) of formula, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall

If "I DO NOT KNOW/RECALL" checked for any of the above, please explain:

_____

_____

_____

_____

Name of Child	**In the 3 months following birth, was the child administered any of the following (check all that apply):**	
	□ Parenteral feeding (intravenous administration of nutrients)	□ I do not know/recall
	□ Mother's own breastmilk	□ I do not know/recall
	□ Donor milk	□ I do not know/recall
	□ Infant formula product If yes, specify brand and product name(s) of formula, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall
	□ human milk fortifier product If yes, specify brand and product name(s) of fortifier, if known:	□ I do not know/recall

If "I DO NOT KNOW/RECALL" checked for any of the above, please explain:

_____

_____

_____

_____

N. Please identify and describe all advertisements (including the nature and/or specific statements made in such advertising) Mother saw regarding the infant formula or fortifier products identified in Section III.F before the Infant was administered those products.

_____

_____

_____

_____

_____

_____

_____

O. Please identify and describe all advertisements (including the nature and/or specific statements made in such advertising) Mother saw regarding any other infant formula or fortifier products before the Infant was administered the infant formula or fortifier products identified in Section III.F.

_____

_____

_____

_____

_____

_____

_____

Father

A. Full Name: _____

B. Date of Birth: _____

C. For the one-year period prior to the date of completing this PFS, provide the home address(es):

_____

_____

D. Social Security Number (must be provided ONLY IF the Father is seeking damages for pain and suffering and will be used to obtain treatment records for Father's claimed injuries):

_____

E. Medicare/Medicaid Identifier (must be provided ONLY IF the Father is seeking damages for pain and suffering and will be used to obtain treatment records for Father's claimed injuries): _____

F. Current Occupation: _____

G. Current Employer: _____

H. ONLY if the Father is a named Plaintiff in the Complaint, answer the following:

1. During the past 10 years, has Father been convicted of or pled guilty to a felony criminal charge?

___ YES ___ NO ___ N/A (if Father is not a named Plaintiff)

If YES, please state the offense, the claim number (if any), the date of conviction or plea and whether the conviction has been expunged, and the court where the conviction or plea was entered:

_____

_____

_____

_____

I. ONLY if the Father is a named Plaintiff in the Complaint, answer the following:

1. Has Father ever filed a Social Security or other disability claim relating to the Infant's alleged injury?

___ YES ___ NO ___ N/A (if Father is not a named Plaintiff)

If YES, please state the year the claim was filed, where the claim was filed, claim/docket number (if applicable), nature of disability, period of disability, and outcome of claim:

J. Please identify and describe all advertisements (including the nature and/or specific statements made in such advertising) Father saw regarding the infant formula or fortifier products identified in Section III.F before the Infant was administered those products.

K. Please identify and describe all advertisements (including the nature and/or specific statements made in such advertising) Father saw regarding any other infant formula or fortifier products before the Infant was administered the infant formula or fortifier products identified in Section III.F.

V. DAMAGES

Please complete the questions in Section V with respect to the Infant in this case and any other plaintiffs.

Infant

A. Does Plaintiff claim the Infant suffered a physical injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the physical injury:

_____

_____

_____

_____

B. Does Plaintiff claim the Infant suffered a psychiatric and/or psychological injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the psychiatric and/or psychological injury:

_____

_____

_____

_____

C. For each alleged physical and/or psychiatric and/or psychological injury identified in Sections V.A or V.B, state the date or date range of treatment, the Healthcare Provider, and the insurers or other third-party payors.

Injury	Dates or Date Range of Treatments	Name and Address of Healthcare Provider	Name of Insurance Co. and Policy #/Other Third Party Payor

Mother

D. Does Plaintiff claim the Mother suffered a physical injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the physical injury:

_____

_____

_____

_____

E. Does Plaintiff claim the Mother suffered a psychiatric and/or psychological injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the psychiatric and/or psychological injury:

_____

_____

_____

_____

(continued next page)

F. For each alleged physical and/or psychiatric and/or psychological injury identified in Sections V.D or V.E, state the date or date range of treatment, the Healthcare Provider, and the insurers or other third-party payors.

Injury	Dates or Date Range of Treatments	Name and Address of Healthcare Provider	Name of Insurance Co. and Policy #/Other Third Party Payor

Father

G. Does Plaintiff claim the Father suffered a physical injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the physical injury:

_____

_____

_____

_____

H. Does Plaintiff claim the Father suffered a psychiatric and/or psychological injury as a result of the infant formula or fortifier products identified in Section III.F?

___ YES ___ NO

If YES, please state the nature of the psychiatric and/or psychological injury:

_____

_____

_____

_____

I. For each alleged physical and/or psychiatric and/or psychological injury identified in Sections V.G or V.H, state the date or date range of treatment, the Healthcare Provider, and the insurers or other third-party payors.

Injury	Dates or Date Range of Treatments	Name and Address of Healthcare Provider	Name of Insurance Co. and Policy #/Other Third Payor

VI. DOCUMENT PRODUCTION

To the extent not already produced, please produce all documents identified, relied upon, or referenced in this Fact Sheet, including medical records and Letters of Administration or other documents establishing Plaintiff is the personal representative of the decedent's estate.

VII. COUNSEL IDENTIFICATION

Please provide the name and address of your counsel in connection with this claim:

_____

_____

VIII. PREPARATION OF FACT SHEET

Please provide the name and address of any non-party other than counsel who provided information contained within or assisted with preparing this Fact Sheet:

_____

_____

_____

VERIFICATION

I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Plaintiff's Signature: _____ Date: _____

Plaintiff's Signature: _____ Date: _____