WAGNERS
A SERIOUS INJURY LAW FIRM

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MIRAMICHI FORCEPS CLASS ACTION INTAKE FORM

Date: _____

Claimant's Name (Individual who underwent biopsy or other procedure):

_____

First *Middle* *Last*

If Claimant is deceased, please check _____ **Date of Death: _____**

Claimant Address:

_____

_____

_____

Contact Address (If Claimant deceased):

_____

_____

_____

Home Phone: _____

Cell Phone: _____

Facsimile: _____

Email: _____

Remainder of this form pertains to information about the Claimant

Date of Birth: _____

Place of Birth: _____

Social Ins. #: _____

Health Card #: _____

Occupation: _____

Employer: _____

Retired: Yes _____ No _____

Marital Status:

Single: _____ Married: _____ Common Law: _____

Divorced: _____ Widowed: _____ Separated: _____

Divorce Date: _____ Widowed Date: _____ Separated Date: _____

Spouse:

Name_____
First Middle Last

Date of Birth: _____

S.I.N. No.: _____ H.C. No._____

Children (Only to be completed if Claimant is Deceased and child is under 19 years of age):

1) Name_____
First Middle Last

Date of Birth: _____

S.I.N. No.: _____ H.C. No._____

2) Name_____
First Middle Last

Date of Birth: _____

S.I.N. No.: _____ H.C. No._____

3) Name_____
First Middle Last

Date of Birth: _____

S.I.N. No.: _____ H.C. No._____

4) Name_____
First Middle Last

Date of Birth: _____

S.I.N. No.: _____ H.C. No._____

History:

Did you undergo a biopsy or other procedure at the Miramichi Hospital's colposcopy clinic between 1999 & May 24, 2013?: Yes _____ No _____

What was the date that the biopsy or other procedure was performed?: _____

Did you undergo more than one biopsy or procedure? Yes ____ No _____

What were the dates?: _____

_____

_____

What was/were the diagnosis?: _____

_____

Has the Horizon Health Network contacted you to advise you of the colposcopy clinic's failure to follow recommended procedure for cleaning and sterilizing of its forceps?

Yes _____ No _____

Have you undergone testing to determine if you have contracted any of the following:

Hepatitis B Yes _____ No _____

Hepatitis C Yes _____ No _____

HIV Yes _____ No _____

Please advise of the results if you have received them:

_____

_____

_____

_____

_____

Please note that we will never contact any persons listed below without your express consent.
Family Doctor(s):

Provide details of doctors who would possess medical records related to medical conditions and/or treatment received with respect to any procedures or biopsies:

Name: _____ Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

_____ _____

Specialist(s):

Provide details of any Medical Specialists you have seen regarding any procedures or biopsies:

Name: _____ Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

_____ _____

Other Physician(s)/Hospital(s):

Provide details of any other medical practitioner or facility that would possess medical records related to medical conditions and/or treatment received with respect to any procedures or biopsies:

Name: _____ Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

_____ _____

Pharmacies:

Provide details of pharmacies that would possess your prescription records:

Name: _____ Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

_____ _____