TDF – Plaintiff Fact Sheet:

I. Patient Information:

A) First Name: XXXX **Middle Name:** XXXX **Last Name:** XXXX

B) Maiden Name: XXXX

C) Gender: Male

D) Social Security Number: XXXX

E) Date and place of birth: *Unknown*

F) Current height and weight: 1.72 m and 137.8 lbs.

G) Ethnicity: *N/A*

H) Current Address: XXXX, NC

I) Prior Address: From *N/A*

II. Diagnosis and TDF Use Details:

A) Have you been diagnosed with HIV, if yes, please fill the below questions:

Date of Diagnosis *I do not recall*

Name of Healthcare Provider who diagnosed and his/her address *I do not recall*

B) Have you been diagnosed with Hepatitis B virus, if yes, please fill the below questions:

Date of Diagnosis *I do not recall*

Name of Healthcare Provider who diagnosed and his/her address *I do not recall*

C) Were you prescribed with TDF medication, if yes, please fill the below questions:

Name of Medication: Prezcobix

Dates of use: 05/31/2019

Name of Healthcare Provider who prescribed and his/her address XXXX, M.D. – Address not available

Date and reason for discontinuation *I do not recall*

Name of Healthcare Provider who discontinued and his/her address *I do not recall*

Name of Medication: Atripla

Dates of use: From 1995 **to** 2006

Name of Healthcare Provider who prescribed and his/her address *N/A*

Date and reason for discontinuation *I do not recall*

Name of Healthcare Provider who discontinued and his/her address *I do not recall*

Name of Medication: Truvada

Dates of use: From 2007 **to** 2009

Name of Healthcare Provider who prescribed and his/her address *N/A*

Date and reason for discontinuation *I do not recall*

Name of Healthcare Provider who discontinued and his/her address *I do not recall*

III. TDF Injury:

A) Were you diagnosed with a kidney disease from your use of TDF medication, if yes, please fill the below questions:

1) Name of the TDF medication that caused your kidney injury Atripla and Truvada

2) Type of kidney injury Chronic kidney disease stage 4

3) Date of onset of injury *I do not recall*

4) Date of diagnosis 12/21/2018-05/31/2019

5) How did you first become aware of the injury *I do not recall*

6) Name of Healthcare Provider who diagnosed and his/her address

XXXX, M.D./XXXX, DNP, FNP

7) Treatment details Medical Management and Monitoring: Started outpatient dialysis on XX/XX/2018 at XXXX Care. He is dialyzing on a second shift Monday, Wednesday, Friday scheduled for 4 hours and 30 minutes using a 180NRe Optiflux, using a standard bath, at a BFR of 400 to a dry weight of 117.50 lbs.

8) Current symptoms, if any *I do not recall*

9) Any past history of kidney disease prior to the use of your TDF medication, if yes, please fill the details.

Date of diagnosis: *I do not recall*

Treatment details: *I do not recall*

Date of diagnosis: *I do not recall*

Treatment details: *I do not recall*

10) Have you ever had a kidney-related test or procedure performed, if yes, please fill the below details:

Name of test or procedure performed Creatinine

Date of test or procedure performed 05/30/2019

Reason for test or procedure performed CKD

Results of the test or procedure performed 4.76 mg/dL (High)

Name of Healthcare Provider who performed or ordered *I do not recall*

Name of test or procedure performed Glomerular Filtration Rate (GFR)

Date of test or procedure performed 05/30/2019

Reason for test or procedure performed CKD

Results of the test or procedure performed GFR NAA: 12 mL/Min (Low), GFR AA: 15 mL/Min (Low)

Name of Healthcare Provider who performed or ordered *I do not recall*

11) Have you ever taken any over-the-counter mediation for the treatment of kidney disease, if yes, please fill the below questions:

Name of medication Hydralazine

Dates of use: 05/31/2019

Name of Healthcare Provider who prescribed XXXX, M.D

Reason for discontinuation N/A

Name of Healthcare Provider who discontinued N/A

B) Were you diagnosed with a bone injury your use of TDF medication, if yes, please fill the below questions:

1) Name of the TDF medication that caused your bone injury *None noted in the available medical records*

2) Type of bone injury _____

3) Date of onset of injury _____

4) Date of diagnosis _____

5) How did you first become aware of the injury _____

6) Name of Healthcare Provider who diagnosed and his/her address _____

7) Treatment details _____

8) Current symptoms, if any _____

9) Any past history of bone injury or disease prior to the use of your TDF medication, if yes, please fill the details.

Date of diagnosis: *None noted in the available medical records*

Treatment details: _____

Date of diagnosis: _____

Treatment details: _____

10) Have you ever had a bone-related test or procedure performed, if yes, please fill the below details:

Name of test or procedure performed *None noted in the available medical records*

Date of test or procedure performed _____

Reason for test or procedure performed _____

Results of the test or procedure performed _____

Name of Healthcare Provider who performed or ordered _____

11) Have you ever taken any over-the-counter medication for the treatment of bone disease, if yes, please fill the below questions:

Name of medication *None noted in the available medical records*

Dates of use: From _____ to _____

Name of Healthcare Provider who prescribed _____

Reason for discontinuation _____

Name of Healthcare Provider who discontinued _____

C) Were you diagnosed with any other injury from your use of any TDF medication, if yes, please fill the below questions:

1) Name of the TDF medication that caused your injury *I do not recall*

2) Type of injury _____

3) Date of onset of injury _____

4) Date of diagnosis _____

5) How did you first become aware of the injury _____

6) Name of Healthcare Provider who diagnosed and his/her address _____

7) Treatment details _____

8) Current symptoms, if any _____

9) Any past history of other injury or disease prior to the use of your TDF medication, if yes, please fill the details.

Date of diagnosis: *12/21/2018*

Treatment details: Heart failure with reduced ejection fraction and coronary artery disease

Date of diagnosis: *12/21/2018*

10) Have you ever had a related test or procedure performed, if yes, please fill the below details:

Name of test or procedure performed Upper arm A-V graft with central banding; left brachial artery endarterectomy

Date of test or procedure performed 09/30/2019

Reason for test or procedure performed Left upper extremity steal sydrome as well as left upper extremity embolus

Results of the test or procedure performed *N/A*

Name of Healthcare Provider who performed or ordered *N/A*

11) Have you ever taken any over-the-counter medication for the treatment of this disease, if yes, please fill the below questions:

Name of medication *Amlodipine*

Dates of use: 05/31/2019

Name of Healthcare Provider who prescribed XXXX, M.D.

Reason for discontinuation *I do not recall*

Name of Healthcare Provider who discontinued *I do not recall*

IV. Treating Facility:

A) Identify each Healthcare Facility/Hospital or Clinic that provides you treatment from the 5 years prior to your first use of TDF medication till the present:'

Name and address of facility XXXX Neurology

Dates of treatment: 12/21/2018

Reason for admission Hemodialysis

Name and address of facility XXXX, Wound Care Center

Dates of treatment: 11/11/2019

Reason for admission Wound care

Name and address of facility XXXX Kidney Care

Dates of treatment: From 2018-present

Reason for admission CKD

V. Healthcare Providers:

A) Identify each Healthcare Provider from whom you have received treatment from the 5 years prior to your first use of TDF medication till the present:

Name and address of provider XXXX, DNP, FNP

Dates of treatment: 12/21/2018

Reason for admission Annual dialysis

Name and address of provider XXXX, M.D.

Dates of treatment: 10/07/2019

Reason for admission Transplant Surgery

Name and address of provider XXXX, M.D.

Dates of treatment: 10/07/2019

Reason for admission Transplant Surgery

VI. Pharmacy Information:

A) Identify each Pharmacy that had dispensed you a medication from the 7 years prior to your first of TDF medication till the present:

Name of Pharmacy and address: XXXX Health Care System

Dates of use: From 1995 to 2009