XARELTO INITIAL INTAKE

Date: ___ / ___ / _____

Intake Performed By: _____

I. PERSONAL INFORMATION

INJURED CLAIMANT INFORMATION

Name of Injured / Deceased: _____

Date of Birth: ___ / ___ / _____ Date of Death: ___ / ___ / _____

PRIMARY CONTACT INFORMATION

Name: _____ Home Phone: ( )_____-_____

Home Address: _____ Cell Phone: ( ) _____ - _____

_____ Work Phone: ( )_____-_____

E-mail:_____

Relationship to Claimant if other than Claimant: _____

Additional Contact Person: Please list the name of a contact person who will know how to reach you if we are unable to contact you:

Name: _____ Relationship: _____

Home Number: _____ Work Number: _____

If Death, Has an Estate Been Opened for the Deceased Claimant?

□ **Yes** □ **No**

If so, who is the Personal Representative? (Please provide name and contact information)

Name: _____ Home Phone: ( )_____-_____

Home Address: _____ Cell Phone: ( ) _____ - _____

_____ Work Phone: ( )_____-_____

E-mail:_____

II. WRONGFUL DEATH INFORMATION

Date of Death: _____ Place of Death: _____

Cause of Death as listed on death certificate (if known):

_____

III. XARELTO HISTORY

A. When did the injured claimant take Xarelto?

Date Started: _____ / _____ / _____

Date Stopped: ___ / ___ / _____

Still Taking: Yes_____/No_____

City & State where Xarelto was prescribed: _____

City and State where prescription was filled: _____

City and State where injury occurred: _____

City and State of residency while taking Xarelto: _____

B. Why was the injured claimant prescribed Xarelto?

_____

_____

C. Why did the injured claimant stop taking Xarelto?

_____

_____

Did the injured claimant ever experience the following **while taking Xarelto or within 10 days of taking Xarelto**?

*When performing intake, if a prospective client answers "yes" to any of the below, get the most accurate date (even if it is an approximate date) of when this occurred. This is necessary for calculating statutes of limitations. **DO NOT leave this blank**.*

1. Gastrointestinal Bleeding □ **Yes** □ **No** **If yes, when _____**
2. Brain Bleed/Intracranial Bleeding □ **Yes** □ **No** **If yes, when _____**
3. Other Internal Bleeding □ **Yes** □ **No** **If yes, when _____**

If yes, please explain as to each experience the injured claimant had above in more detail:

_____

_____

_____

_____

D. Did the injured claimant go to the hospital for any of these symptoms/conditions? □ **Yes** □ **No**

If yes, approximately how many times had the injured claimant been in the hospital for any of these symptoms/conditions?

_____

_____

Also if yes, approximately how many days total had injured claimant been in the hospital for any of these symptoms/conditions?

_____

_____

E. Has a doctor told injured claimant that Xarelto was responsible for any of these symptoms/conditions? □ **Yes** □ **No**

If yes, what is the name and location of the physician?

_____

_____

Also if yes, briefly explain what the doctor told you:

_____

_____

IV. STATUTES OF LIMITATION INFORMATION

When did the injured claimant connect their injuries with Xarelto? _____
(month/year)

How did this connection occur? _____
(e.g., research?/doctor-provided information?/television ad.?)

V. ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____