

**PRADAXA 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. PRADAXA HISTORY**

A. When did the injured claimant take Pradaxa?

Date Started: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date Stopped: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Still Taking: Yes \_\_\_\_ / No \_\_\_\_

City & State where Pradaxa was prescribed: \_\_\_\_\_

City and State where prescription was filled: \_\_\_\_\_

City and State where injury occurred: \_\_\_\_\_

City and State of residency while taking Pradaxa: \_\_\_\_\_

B. Why was the injured claimant prescribed Pradaxa?

\_\_\_\_\_  
\_\_\_\_\_

C. Why did the injured claimant stop taking Pradaxa?

\_\_\_\_\_  
\_\_\_\_\_

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

\*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** \_\_\_\_\_

4. Other Notable Bleeding Events            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?

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

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

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

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

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**IV. STATUTES OF LIMITATION INFORMATION**

When did the injured claimant connect their injuries with Pradaxa? \_\_\_\_\_  
(month/year)

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

**V. ADDITIONAL COMMENTS:**

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