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CONFIDENTIAL PRIVILEGED ATTORNEY CLIENT WORK PRODUCT

**TRASYLOL™ (aprotinin injection)
 CLIENT QUESTIONNAIRE**

PLEASE provide medical & billing records associated with heart surgery.

Information of Injured Party:

Name:			
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Work Phone:	Email Address:		
Date of Birth:	Social Security No.	Sex:	(M or F)

If you are completing this form on behalf of a minor or decedent, please complete your information in this section:

Name:			
Address:			
City:	State:	Zip:	
Home Phone:	Cell Phone:		
Work Phone:	Email Address:		
Relationship to Claimant:			

HEART SURGERY INFORMATION

Hospital where surgery was performed:	Name: _____ Address: _____ City: _____ State: ___ Zip: _____ Phone No.: _____
Heart Surgeon:	Name: _____ Address: _____ City: _____ State: ___ Zip: _____ Phone No.: _____
Have you or a loved one experienced any of the following?	<input type="checkbox"/> Kidney Damage <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Death

By signing below, you hereby grant Frank J. D'Amico, Jr., APLC the authority to investigate your (loved one's) potential claim arising from the possible injection of Trasylol during a heart surgery.

Claimant Signature

Date