SCHEDULE D -- PHYSICIAN DECLARATION FORM

In completing this Form, you may consider the patient's medical records, charts, reports, diagnostic films, medical history, or other sources of information that physicians regularly and routinely rely upon in their practice. By signing this Form, you certify that all opinions set forth below are offered to a reasonable degree of medical certainty.

1. PHYSICIAN BACKGROUND

(First Name) (Middle Initial) (Last Name)

(Office Address)

(City) (Province) (Postal Code)

(Area Code & Telephone Number) (Fax Area Code & Number)

Check whether you are a/an:

- ☐ Orthopedic surgeon
- ☐ Cardiologist
- ☐ Neurologist
- ☐ Cardiothoracic surgeon
- ☐ Neurosurgeon
- ☐ Other _____

College of Physicians and Surgeons Registration Number:_____

2. PATIENT INFORMATION

State the name and birth date of the patient for whom you are providing the information contained in this Physician Declaration Form.

(First Name) (Middle Initial) (Last Name)

(Birth Date MM/DD/YYYY)

Are you one of the patient's treating physicians?

☐ Yes ☐ No

If "Yes," state your role in the patient's medical care and treatment relative to his/her ASR™ XL Acetabular Hip System and/or ASR™ Hip Resurfacing System implant and/or Revision Surgery:

3. IMPLANT INFORMATION

State the reference and catalog numbers that correspond to the patient's ASR™ XL Acetabular Hip System and/or ASR™ Hip Resurfacing System.

Date of Implantation (Right) _____
(MM/DD/YYYY)

Implant Reference/Catalogue Numbers _____
(if available)

Implant Lot Number _____
(if available)

Date of Implantation (Left) _____
(MM/DD/YYYY)

Implant Reference/Catalogue Numbers _____
(if available)

4. REVISED PATIENT

Has the patient been diagnosed as medically requiring a revision surgery to replace the cup of his or her ASR™ XL Acetabular Hip System and/or ASR™ Hip Resurfacing System?

□ Yes □ No

If "Yes," please answer the remaining questions in section 4, If "No," please skip to section 6.

Date of the diagnosis: _____
(MM/DD/YYYY)

5. SCHEDULED REVISION

Has a revision surgery been scheduled? □ Yes □ No

If "Yes," if the person was placed on a waiting list to have the surgery, enter the date the person was placed on the list: _____
(MM/DD/YYYY)

If "Yes," the date the surgery is scheduled to occur: _____
(MM/DD/YYYY)

Has the surgery occurred? □ Yes □ No

If "Yes," date on which the revision surgery took place: _____
(MM/DD/YYYY)

Describe all reason(s) a revision surgery for the cup of the ASR™ XL Acetabular Hip System and/or ASR™ Hip Resurfacing System has been diagnosed and identify all testing or films taken and the results that support this diagnosis:

_____

_____

6. COMPLICATIONS RESULTING FROM REVISION SURGERY

☐ Check here if the patient underwent a revision surgery or surgeries to remove the cup of his/her ASR™ XL Acetabular Hip System and/or ASR™ Hip Resurfacing System (referred to herein as "ASR Revision Surgery").

If you checked the box above, and the patient sustained any of the following complications during or after his/her ASR Revision Surgery due to the ASR Revision Surgery, please state the date on which the complication(s) occurred:

	DATE (MM/DD/YYYY)
(a) Blood Clot means a diagnosis made within 72 hours of an ASR Revision Surgery of pulmonary embolism or deep vein thrombosis that resulted from the ASR Revision Surgery and which required a new hospitalization or extended the hospitalization after the ASR Revision Surgery. Please include records of any prior PE/DVT history.	
(b) Infection means any infection in the revised hip that is diagnosed within 30 days after the ASR Revision Surgery and determined to have been caused by the ASR Revision Surgery and which required one of the following: (i) eight weeks of intravenous antibiotic treatment, (ii) surgical debridement with prosthesis retention, (iii) implantation with an antibiotic spacer; or (iv) arthrodesis. However, excluded from this complication are infections caused by an organism where the contemporaneous medical records reflect that this organism was identified pre-ASR Revision Surgery, but was not shown to be eradicated prior to the ASR Revision Surgery.	
(c) Permanent Peroneal Nerve Damage or Foot Drop resulting in an inability to lift the front part of the foot from permanent nerve damage caused by the ASR Revision Surgery and was diagnosed during the hospitalization for the ASR Revision Surgery, has lasted 90 days and in your opinion is permanent.	

Please attach to this form medical records that are contemporaneous to the ASR Revision Surgery and any of the Complications above that are applicable and that confirm that the Complication(s) noted above occurred. Such medical records may include, but are not limited to, operative reports, pathology reports, office records, and/or discharge summaries.

DECLARATION

I affirm that the foregoing representations are true and correct.

Executed on _____.

By: _____
Signature of Physician

_____
Printed Name