

**SCHEDULE F -- 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 Durom Cup implant:

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### 3. IMPLANT INFORMATION

**State the reference and catalog numbers that correspond to the patient's Durom Acetabular Cup ("Durom Cup")**

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 requiring a revision surgery to replace the Durom Cup?

Yes No

If "Yes," please answer the remaining questions in section 4. If "No," please skip to section 8.

Date of the diagnosis: \_\_\_\_\_  
(MM/DD/YYYY)

Has a revision surgery been scheduled? Yes No

If "Yes," date on which the surgery was scheduled: \_\_\_\_\_

(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 Durom Cup has been diagnosed and identify all testing or films taken and the results that support this diagnosis:

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### 5. UNREVISED PATIENT WHERE REVISION SURGERY IS CONTRAINDICATED

If a revision surgery has not been scheduled or will not take place, is there a medical condition that prevents the patient from undergoing a revision surgery ("Contraindication")? Yes No

If "Yes," describe the Contraindication(s) that prevent(s) replacement of the Durom Cup, and state whether the Contraindication(s) is/are temporary or permanent:

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Provide the date on which you determined that a revision surgery for the patient was Contraindicated:

\_\_\_\_\_  
(MM/DD/YYYY)

### 6. COMPLICATIONS RESULTING FROM REVISION SURGERY

Check here if the patient underwent a revision surgery or surgeries to remove his/her Durom Cup(s).

If you checked the box above, and the patient sustained any of the following complications during our after his/her revision surgery, please state the date on which the complication(s) occurred:

DATE  
(MM/DD/YYYY)

- (a) A second revision (Right) \_\_\_\_\_  
A second revision (Left) \_\_\_\_\_
- (b) A third revision (Right) \_\_\_\_\_  
A third revision (Left) \_\_\_\_\_
- (c) Stroke that occurred within 72 hours after a  
revision surgery to remove a Durom Cup as a result of  
that surgery \_\_\_\_\_
- (d) Blood clot that occurred within 72 hours after a  
revision surgery to remove a Durom Cup as a result of  
that surgery \_\_\_\_\_
- (e) Infection in the revised hip that was diagnosed within 30  
days after a revision surgery to remove a Durom Cup  
and was caused by that surgery \_\_\_\_\_
- (f) Permanent nerve damage resulting from a revision  
surgery to remove a Durom Cup \_\_\_\_\_
- (g) Death within 72 hours after a revision surgery  
to remove a Durom Cup that resulted from that surgery \_\_\_\_\_

**Please attach medical records to this form 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.**

**7. DECLARATION**

I affirm that the foregoing representations are true and correct.

Executed on \_\_\_\_\_, 201\_\_.

By: \_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Print Name