Form 115 (version 2)
UCPR 58.2

OPT OUT NOTICE

COURT DETAILS	
Court	Supreme Court of New South Wales
Division	Common Law
List	Professional Negligence
Registry	Sydney
Case number	2017/279308
TITLE OF PROCEEDINGS	
First plaintiff	**Amy Rickhuss**
Number of plaintiffs	12
First defendant	**The Cosmetic Institute Pty Ltd (In Liquidation)**
Number of defendants	19
FILING DETAILS	
Filed for	, person opting out of representative proceedings
Legal representative	
Legal representative reference	
Contact name and telephone	
Contact email	

OPT OUT NOTICE

Name of person opting out:
Address of person opting out:

I,.. , a group member in this representative proceeding, opt out of the proceeding.

I understand that in opting out:

1. I forego the right to share in any relief obtained by the representative parties in the representative proceeding;
2. I am not entitled to receive any further notification about the conduct or disposition of the proceeding; and
3. To the extent that I have a claim against the defendants, any limitation period suspended by the commencement of the representative proceeding, has recommenced running.

SIGNATURE

Signature of or on behalf of person
opting out

Capacity

Date of signature

NOTICE TO PERSON OPTING OUT

You must, within the time specified in the notice to group members do either of the following:

1. File this form in the registry of the court at the address below, or in the manner provided in the notice to group members and serve a copy of this form on the representative party (Turner Freeman Lawyers) at the address, or in the manner provided, in the notice to group members.

   OR

2. Complete this form and email a copy of it to Sally.Gleeson@turnerfreeman.com.au and request in your email that Turner Freeman Lawyers file this form in the court on your behalf. Turner Freeman Lawyers will file your form and confirm by email to you that the form has been filed within three business days of receiving your email. If you do not receive a confirmation email from Turner Freeman Lawyers that this form has been filed for you, please call Sally Gleeson at Turner Freeman Lawyers on (02) 8222 3333.

REGISTRY ADDRESS	
Street address	Supreme Court of NSW Law Courts Building, Queen's Square 184 Phillip Street Sydney NSW 2000
Postal address	Supreme Court of NSW GPO Box 3 Sydney NSW 2001
Telephone	1300 679 272

REGISTRATION FOR SETTLEMENT NOTICE

COURT DETAILS	
Court	Supreme Court of New South Wales
Division	Common Law
List	Professional Negligence
Registry	Sydney
Case number	2017/279308
TITLE OF PROCEEDINGS	
First plaintiff	**Amy Rickhuss**
Number of plaintiffs	12
First defendant	**The Cosmetic Institute Pty Ltd (In Liquidation)**
Number of defendants	19
FILING DETAILS	
Filed for	, person registering for settlement
Legal representative	
Legal representative reference	
Contact name and telephone	
Contact email	

REGISTRATION FOR SETTLEMENT NOTICE

Name of person registering for settlement:

Address of person registering for settlement:

I, …………………………………., a group member in this representative proceeding:

1. wish to register for settlement so that I may receive any benefit obtained from the proceeding.
2. have completed the attached Questionnaire to the best of my ability and enclosed any relevant photographs, medical records, or other evidence available to me.
3. have read, and understand, the content of the Notice and the consequences of registration.

SIGNATURE

Signature of or on behalf of person registering

Capacity

Date of signature

NOTICE TO PERSON REGISTERING FOR SETTLEMENT

You must, within the time specified in the notice to group members do either of the following:

1 Complete this form and email a copy of it to Sally.Gleeson@turnerfreeman.com.au.

Turner Freeman Lawyers will confirm by email to you that the form has been received within three business days of receiving your email. If you do not receive a confirmation email from Turner Freeman Lawyers, please call Sally Gleeson at Turner Freeman Lawyers on (02) 8222 3333.

IN THE SUPREME COURT OF NEW SOUTH WALES

Case number: 2017/279308

Amy Rickhuss & Others v The Cosmetic Institute Pty Ltd, Dr Eddy Dona & others

QUESTIONNAIRE

DATE this form was completed:

....

PERSONAL DETAILS

Salutation (Ms / Miss / Mrs / Dr / Other)

....

Name

....

Address

....

....

Date of Birth (dd/mm/yyyy)

....

Email

....

If you are unable to complete any part of this section of the form because you do not know the answers to the questions, you may seek advice from your treating doctor.

TCI – DESIRED RESULTS

What results did you want from your breast augmentation surgery?	□ Larger breasts
	□ Improve the aesthetic appearance of your breasts (to look better)
	□ Restore your breasts after pregnancy, breast feeding, aging or other conditions?
	□ Improve your self-esteem/ confidence
	□ Other reasons (please specify)

PRIOR BREAST AUGMENTATION SURGERY

Was your breast augmentation surgery with TCI the first breast augmentation surgery you have had?

□ Yes.

□ No. If not please write below:

- The date of each breast augmentation surgery you had before your surgery with TCI
- The name of the surgeon who performed your breast augmentation surgery.
- Where the surgery was performed.
- The reason/s why you had this surgery.
- Whether it related to the left, right or both breasts.

FIRST TCI BREAST AUGMENTATION SURGERY

Date of first TCI breast augmentation surgery:	
TCI Surgeon who you consulted with before the surgery:	
TCI surgeon who performed your surgery:	
TCI anaesthetist involved in your breast augmentation surgery:	
Place of first breast augmentation surgery (please tick):	□ TCI Parramatta □ TCI Bondi □ TCI Southport □ TCI Parramatta Premises □ Concord Private Hospital □ Holroyd Private Hospital □ Do not know
Type of breast implants inserted:	□ Round implants – tick if you had round implants □ Other implants – please specify shape of implants □ Do not know
Brand of implants	□ Allergan implants – tick if you had round implants □ Other implants – please specify brand of implants
Placement of implants	□ Subpectoral placement (under the muscle) □ Subglandular placement (over the muscle) □ Dual plane (partly under and partly over the muscle) □ Do not know

Did your TCI surgeon advise you that you may need a mastopexy or a breast lift **before** your first breast augmentation surgery with TCI? (Please tick)	□ No □ Yes □ Do not recall □ Do not know If yes: Did you sign a form to say that although you understood that suboptimal results will only be achieved with your breast augmentation surgery, you wanted to have it anyway? □ No □ Yes
Prior to the breast augmentation surgery, did TCI refer you to Dr Eddy Dona to discuss having a mastopexy or breast lift performed by him?	□ No □ Yes □ Do not recall □ Do not know
Prior to the breast augmentation surgery, did TCI offer to refer you to Dr Eddy Dona to discuss having a mastopexy or breast lift performed by him and you declined this offer?	□ No □ Yes □ Do not recall □ Do not know If yes, please advise your reasons. …………………………………………………………………………… ……………………………………………………………………………

FURTHER TCI BREAST SURGERY

Please ONLY complete this section below if you have had more than one breast surgery with TCI. This surgery includes further augmentation surgery, removal of implants, debridement, wash out, drainage of haematomas or infections.

Second breast surgery with TCI (only complete this if you have undergone such a surgery with TCI):

Date of surgery:

Name of surgeon:

Place of surgery:

Reason/s for having this surgery (for example, infection, ruptured implant, to correct the cosmetic outcome from your surgery with TCI):

Details of what surgery was performed and if it related to the left/right or both breasts:

Details of what implant/s were used:

Third breast surgery with TCI (only complete this if you have undergone such a surgery with TCI):

Date of surgery:

Name of surgeon:

Place of surgery:

Reason/s for having this surgery (for example, infection, ruptured implant, to correct the cosmetic outcome from your surgery with TCI):

Details of what surgery was performed and if it related to the left/right or both breasts:

Details of what implant/s were used:

Fourth or more breast surgery with TCI: If you have had four or more breast surgeries with TCI please write details in relation to each surgery below (as you did with the previous breast surgeries i.e. write the date of the surgery, who performed it, place where it was performed, reason/s for having the surgery, details of the surgery and implant/s used):

INDEPENDENT BREAST SURGERY – not related to TCI

This surgery includes further augmentation surgery, removal of implants, debridement, wash out, drainage of haematomas, or infections.

After any breast augmentation surgery with TCI, have you had further breast surgery, which was NOT performed with TCI? This can include surgery performed by Dr Eddy Dona through his private practice.	□ No. (If no, you do not have to complete the details below). □ Yes. (If so, please complete the details below)

First independent breast surgery unrelated to TCI (only complete this if you have undergone such a surgery):

Date of surgery:	
Name of surgeon:	
Place of surgery:	
Reason/s for having this surgery (for example, infection, ruptured implant, to correct the cosmetic outcome from your surgery with TCI):	
Details of what surgery was performed and if it related to the left/right or both breasts:	
Details of what implant/s were used:	

Second independent breast surgery unrelated to TCI (only complete this if you have undergone such a surgery):

Date of surgery:	
Name of surgeon:	
Place of surgery:	
Reason/s for having this surgery (for example, infection,	

ruptured implant, to correct the cosmetic outcome from your surgery with TCI):

Details of what surgery was performed and if it related to the left/right or both breasts:

Details of what implant/s were used:

Third or more independent breast surgery: If you have had three or more independent breast surgeries unrelated to TCI please provide details of each surgery below (as you did with the previous independent surgeries i.e. write the date of the surgery, who performed it, place where it was performed, reason/s for having the surgery, details of the surgery and implant/s used):

COMPLICATIONS (INJURIES)

Please note that being unhappy with the staff or service provided by TCI (such as being rushed out after the surgery) is not a "Complication". Please provide details of complications, which are injuries (physical or psychological). Some examples of Complications from breast augmentation surgery are outlined below. Please tick "yes" or "no" and complete the details requested in relation to each complication below.

Have you experienced any of the following after any of your breast augmentation surgeries with TCI?

	No	**Yes**	**Do you still suffer from the condition? (please tick)**	**Have you sought treatment for this condition?**
Psychiatric injury (for example, depression, anxiety, post-traumatic stress disorder)	☐	☐	□ Yes □ No	□ No □ Yes, if so, please state the name and address of the doctor/s from whom you have sought treatment and their specialty ....

If you are suffering with
a psychological/psychiatric condition,
had you ever suffered these symptoms before
you had breast implants? If yes, for what
period of time had you had the symptoms
before the implants?

If you had previously suffered with
a psychological/psychiatric condition,
had you ever required treatment before
you had the breast implants? If so, what treatment did you have
(e.g. seeing your GP, Psychologist, or Psychiatrist, and/or being prescribed medication) and for how long?

If you had previously suffered with
a psychological/psychiatric condition,
for which you have required treatment
before you had breast implants, provide
the name/s, specialty and address of the doctor/s
you had treatment with.

	No	Yes	Do you still suffer from the condition? (please tick)	Have you sought treatment for this condition?
Pain If you have pain, where? (Can be more than one location). Please tick: ☐ Left breast ☐ Right breast ☐ Under left breast where surgical incision was made ☐ Under right breast where surgical incision was made ☐ Left nipple ☐ Right nipple ☐ Other:	☐	☐	□ Yes □ No	□ No □ Yes, if so, please state the name and address of the doctor/s from whom you have sought treatment and their specialty ie GP, plastic surgeon etc ....

(Please provide details of where the pain is):

....

....

....

....

	No	Yes	Do you still suffer from the condition? (please tick)	Have you sought treatment for this condition?
Mal-positioned (incorrectly positioned) breast implant/s If so, which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Double bubble or other breast deformity. Please describe the deformity. .... If so, which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Rupture of the implant/s. If so, which implant (it can be both): ☐ Left implant ☐ Right implant	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....

	No	Yes	Do you still suffer from the condition? (please tick)	Have you sought treatment for this condition?
Haemorrhage or haematoma. If so, which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Infection. If so, tick which details below apply to you (it can be more than one): ☐ left breast ☐ right breast ☐ Other. Please specify:	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Scarring: If so, which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Wound dehiscence (the wound edges split apart or separate) If so: Which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....

	No	Yes	Do you still suffer from the condition? (please tick)	Have you sought treatment for this condition?
Contracture of the capsule, implant or muscle If so: Which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Do either of your breasts feel hard? If so, which breast (it can be both): ☐ Left breast ☐ Right breast	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....
Local anaesthetic toxicity, including cardiac arrest, seizures.	☐	☐	□ Yes □ No	□ No □ Yes, if so, provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....

	No	Yes	Do you still suffer from the condition? (please tick)	Have you sought treatment for this condition?
Breast implant-associated anaplastic large-cell lymphoma If so, which breast (it can be both): ☐ Left breast ☐ Right breast **(Please only tick "yes" if you have been diagnosed with this condition by a doctor)**	☐	☐	□ Yes □ No	□ No □ Yes, if so provide the name/s, specialty and address of the doctor/s from whom you sought treatment ....

AESTHETIC OUTCOME

Are you happy with how your breasts look? If not, please provide details of what you are not happy with.

OTHER COMPLICATION/ INJURY

Please write details of any complication/ injury you have suffered as a result of your breast augmentation surgery with The Cosmetic Institute, <u>other</u> than the complications referred to in the above table. Please include the name/s, specialty and address of any doctors from whom you have sought treatment for those condition/s.

....

....

....

....

....

....

....

CURRENT LEVEL OF PAIN

If you experience pain as a complication of your breast augmentation surgery, please rate your pain at its worst in the <u>last week</u> by circling the appropriate number below on a scale of 0 to 10, with 0 being no pain and 10 being the worst imaginable pain.

0 1 2 3 4 5 6 7 8 9 10

CURRENT SEVERITY OF SYMPTOMS

If you were to spend the rest of your life with your symptoms just the way they are now, how would you feel about that?

0 1 2 3 4 5 6 7 8 9 10

Pleased Indifferent Terrible

If you have experienced pain of any level in the past week, how frequently do you experience that level of pain (eg every day, some days, occasionally etc).

....

....

....

ACTIVITIES OF DAILY LIVING

Some women find that complications from their breast augmentation surgery affect their activities, relationships, and feelings (e.g. pain). For each question, check the response that best describes how much your activities, relationships or feelings have been affected by the complications you have suffered. Please tick the box that best describes the impact of the complications over the last 3 months. Please make sure you mark an answer in all 3 columns for each question.

	How do symptoms or conditions in the following affect your:	
1.	Ability to do household chores (cooking, laundry, house cleaning)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
2.	Ability to do physical activities such as walking, swimming, or other exercise?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
3.	Ability to travel by car or bus for a distance greater than 30 minutes away from home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
4.	Participating in social activities outside your home?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit
5.	Emotional health (nervousness, depression, etc.)?	☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

CARE AND ASSISTANCE

Have you required assistance with the activities of daily living (outlined above) i.e. washing, cleaning, showering, preparation of meals, gardening and has that assistance been provided by an external provider, or a friend or member of your family, as a result of the complications you have suffered from the breast augmentation surgery?

☐ Yes

☐ No

If yes:

a.	For which activities did you require assistance (eg washing, cleaning etc).	
b.	When did you start requiring assistance (approximate month and year)?	
c.	Was the assistance provided by a friend, or family member, or was it paid?	
d.	Up until now, on average how many hours of assistance per week have you required?	
e.	If some or all of the assistance was paid, how much do you pay and for which activities do you pay (eg amount paid per fortnight for cleaning)?	
f.	If you think you will require assistance in the future, how many hours of assistance do you think you will require?	
g.	If you think you will require assistance in the future, for which activities will you require assistance?	
h.	If you think you will require assistance in the future, who will provide it ie family or paid assistance?	

ONGOING TREATMENT

Pain Medication

Are you ***currently*** taking any pain medication as a result of your breast augmentation surgery with TCI?	☐ Yes ☐ No
If so, for how many years or months have you been taking the medication?	
What medication do you take? What dosage do you take?	
Did you require pain medication prior to any of your breast augmentation surgery with TCI?	☐ Yes ☐ No
If yes, what medication did you take and what dosage?	

If yes, please provide the name and address of the doctor who prescribed the medication.

Other Medications

Are you ***currently*** taking any medication to treat a psychological condition, infection or other complication you have suffered as a result of your breast augmentation surgery with TCI?	☐ Yes ☐ No
If so, for how many years or months have you been taking medication?	
What medication do you take? What dosage do you take?	
Who prescribed the medication? Please provide the name & address of the doctor/s who prescribed it.	

Other Treatment

Do you ***currently*** receive any other type of treatment as a result of your breast augmentation surgery with TCI (For example, chemotherapy, consultations with a pain management specialist, physiotherapy, psychological treatment etc.)?	☐ Yes ☐ No
If yes, what type of treatment?	
How frequently do you receive this treatment?	

Who provides this treatment? Please provide the name and address of the doctor/s who provides it.

PAYMENT OF YOUR TREATMENT AND REHABILITATION EXPENSES

In answering the following questions, please consider any expenses associated with your breast augmentation surgery with TCI including the costs of revision surgery, consultations with your surgeon or another doctor, medical investigations (such as, x-rays, MRIs or other scans), medication (including Panadol and over the counter medication), consultations with a psychiatrist or psychologist.

Have any of your treatment expenses been *reimbursed or paid directly* by a private health insurer?

☐ Yes. If so, please provide the name of your private health insurer and membership number:

☐ No

Medicare

Have any of your treatment expenses been *reimbursed or paid directly* by Medicare or any other government organisation (such as the Department of Veterans Affairs).

☐ No.

☐ Yes – Medicare. Please provide your Medicare number:

☐ Yes – other government organisation. Please provide details:

First breast augmentation surgery with TCI

Please provide an estimate of the cost of your first breast augmentation surgery with TCI:

☐ $5,990 including GST

☐ Other amount. Please specify: $

Out of pocket expenses (other than the initial cost of your first breast augmentation surgery with TCI)

Are you out of pocket in relation to any treatment and rehabilitation expenses? In other words, have you paid any expenses that have *not* be covered by a private health insurer, Medicare or other government organisation? Please do <u>not</u> include the cost of your first breast augmentation surgery with TCI in this estimate.

☐ Yes

☐ No

If yes, please **estimate** the approximate amount. In answering this question, we do not need you to add up all of your invoices and receipts. Please simply give your best estimate of the total amount.

☐ Less than $1,000

☐ Between $1,000 and $5,000

☐ Between $5,000 and $10,000

☐ More than $10,000. If so, please write an estimate: $

☐ Not able to be estimated. If not, why are you not able to estimate the out of pocket expenses which you have paid for?

Please do **not** attach any receipts/invoices or other records in relation to your pocket expenses to this form unless your expenses total more than $10,000. You should obtain and keep these documents for your own records as we may request these in the future.

EMPLOYMENT STATUS

Were you doing paid work at the time of your breast augmentation surgery with TCI:

☐ Yes

☐ No

If so, were you:

☐ Receiving a wage or salary, or

☐ Working as a contractor, or

☐ Running your own business

If you were working at the time of your breast augmentation surgery with TCI, please answer the following additional questions. If not, please go to the Centrelink section.

What was your job description/position?

If you were receiving a wage or salary, what was the name and address of your employer?

What was your usual income **after** paying tax (as reported in your tax return) for a full year of work?

Did you return to your usual work after your breast augmentation surgery with TCI?

☐ Yes

☐ No

Except for the recovery time advised by your doctor prior to the breast augmentation surgery with TCI, have you required time off work?

☐ Yes

☐ No

If so, approximately how much time did you take off work? (How many hours/days/weeks/months):

If so, have you taken any of the time off work as paid sick and/or annual leave?

□ No
□ Yes

If yes, how much paid sick and/or annual leave did you receive?

If you have not returned to work following your breast augmentation surgery, or if you have had to reduce the hours that you work due to your breast augmentation surgery, what is your current annual income **after** paying tax (according to your tax records)?

Do you think that the injuries from your breast augmentation surgery with TCI will affect your ability to work in the future?

☐ Yes

☐ No

If you ticked yes, please tick one of the following:

☐ Currently working or currently able to work but it is more difficult to do work duties due to injuries, or

☐ Able to continue working and earning the same income but will need time off work for future surgery, or

☐ No longer able to work at all and have stopped working, or

☐ Currently unable to work but will try to return to work in the future, or

☐ Currently working but likely to stop working in the future, or

☐ Currently working at reduced hours and income, or

☐ Needed to change jobs to a different type of job due to injuries.

Please give BRIEF details of any other important information regarding the impact of the breast augmentation surgery with TCI on your enjoyment of life, your income, your capacity to work and your capacity to care for yourself and others, including details of your job title and work (if your injuries have affected your work):

CENTRELINK BENEFITS

Do you currently receive Centrelink benefits?

☐ Yes

☐ No

Have you received Centrelink benefits since your first breast augmentation surgery with TCI?

☐ Yes

☐ No

If so, what type of benefit?

For what periods have you received Centrelink benefits? Please write the dates you started and stopped receiving benefits, or confirm that you continue to receive benefits if they have not stopped.

OTHER CLAIMS

Have you ever made any other claims for compensation in respect of personal injuries suffered by you?

□ Yes
□ **No**

If yes:

What were the injuries for which you made a claim?

Did you receive a settlement/judgment in relation to your claim?

□ Yes
□ **No**

If yes:

How much was the judgment/settlement?

If yes,

When was the judgment/settlement?

Did you claim economic loss in that claim?

□ Yes
□ **No**

If yes, were you partially or totally incapacitated?

PHOTOS MUST BE ATTACHED TO THIS QUESTIONNAIRE FORM

Even if TCI took photographs, or if you provided your photographs to Turner Freeman, you MUST provide this completed questionnaire form to Turner Freeman with a copy of any photographs which you have (or can obtain yourself) from before any breast augmentation surgery with TCI and recent photographs showing your aesthetic outcome (how your breasts look) and any problems (like scarring) which you have.

If you do not have any photographs from before your breast augmentation surgery with TCI and cannot obtain these photos after checking all your emails, mobile and other records, you must at least provide current photographs which you can take yourself.

Each photograph must be dated with the date when the photo was taken and be attached to this form so we can identify the photograph as yours.

In order to ensure all photographs are properly identified you must attach all photographs to this questionnaire form and send them with the completed questionnaire form to Turner Freeman in ONE email to TCI.Forms@turnerfreeman.com.au

PLEASE DO NOT SEND NUMEROUS EMAILS ATTACHING YOUR PHOTOS.