PATIENT NAME 17051007O **MEDICAL HISTORY** **NUMBER** — 648694 **OWNERS NAME**

DATE	DESCRIPTION	CHG	PD
SEP 18 2017	HBC		
27lbs 24lbs	QAR, pink/moist MM, <2sec CRT, p̄ laterally recumbent.		
	T: 101.8 HR: 116 RR: 48		
	EENT: clear OU, no abn discharges.		
	H/L: No HM/arrhy/wheezes/crackles. nml. SSFP.		
	MS: non-ambulatory, pain elicited from palpation of caudal trunk / pelvic area		
	PLNs: normal size PLNs.		
	Abd: Tense, painful abd upon palpation.		
	Neuro: Superficial pain + motor intact in all four limbs.		
	BG: 128 @ 6 pm		
	Radiograph = revealed multiple pelvic fractures. (L) (R) pubis, (R) Ischium ; (R) caudal ileum		
	A: Pelvic fracture Possible spinal injury.		
	P: No microchip scanned. IVC + IVF (LRS + 2.5% dextrose + Bvit) @ 40ml/hr 0.5mg Dexamethasone IV [61] 0.1mg Buprenex IV [61] Check fluid [illegible]		
	p̄ still remains laterally recumbant, unable to ambulate several hours after the injections. But p̄ is responsive and able to lift head up time to time.		
	When p̄ is on (L) lateral recumbency, p̄ showed absent withdrawal reflex on LF + LH limbs, normal on RF + RH limbs. When on (R) lateral recumbency, vice versa. Will monitor for p̄'s response to the initial tx, may euth in 1~2 days if no improvement.		
	p̄ also bit a person during transfer according to the officer.		

PATIENT NAME 17056070 **MEDICAL HISTORY** NUMBER —
OWNERS NAME

DATE	DESCRIPTION	CHG	PD
9/20/17	No appetite, normal urination, no BM overnight T: 99.1 HR: 148 RR: 48 QAR, pink/moist MM, <2sec CRT Mild ptyalism, non-ambulatory, absent deep pain RH limb, absent CP LH & LF. No murmur/arrhy/wheezes/crackles. SSFP Tense abd, normal size pLNs A: HBC Pelvic fracture, non-cumbersome Absent deep pain RH limb R/O spinal injury vs. others. TK P: SQ Fluid 250 mL [89] Feed BID [112] [112] ~~Poor prognosis~~ No improvement since 2 days ago. Grave prognosis if spinal injury 0.5mg Dexamethasone IM [111] $\bar{P}$ still unable to stand & ambulate on own at all. 0.1mg Buprenex IV [15] Re-evaluated $\bar{P}$ @ 7pm, $\bar{P}$ still laterally recumbent/very lethargic but appeared to have distended abdomen. Abdominocentesis revealed serosanguinous fluid. i-Stat of the abd fluid revealed BUN >140, creat 18.2. Urine in the abd, ruptured bladder evident / most likely. Consulted Dr. Grant over the phone, due to the grave prognosis, gotten into an agreement to euthanize $\bar{P}$. 5ml Euthasol given IV [15] Euthanasia confirmed by TK. Medical Records Julie) 741-5565		