1:02:15 a.m. 10-05-2017 | 1

MEDICAL HISTORY

PATIENT NAME: 17051007O

NUMBER — 648692

OWNERS NAME:

DATE	DESCRIPTION	CHG	PD
SEP 18 2017	HBC		
27lbs 24lbs	QAR. pink/moist MM. <2sec CRT. P laterally recumbent.		
	T: 101.8 HR: 116 RR: 48		
	EENT: clear OU. no abn discharges.		
	H/L: No HM/arrhy/ wheezes/ crackles. nml eb. SSTP.		
	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]		
	P still remains laterally recumbant, unable to ambulate several hours after the injections.		
	But P is responsive and able to lift head up time to time.		
	When P is on (L) lateral recumbency, P showed absent withdrawal reflex on LF & LH limbs, normal on RF & RH limbs. When on (R) lateral recumbency, vice versa.		
	Will monitor for P's response to the initial tx, may euth in 1-2 days if no improvement.		
	P 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		