

# FELINE MEDICAL RECORD

|                                                                                                                                            |                     |                                 |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------|--------------------------|
| ANIMAL NAME<br><i>Maggie</i>                                                                                                               |                     | SPECIES<br><i>Feline</i>        | D.O.B.<br><i>4/11/02</i> |
| SEX<br><input type="checkbox"/> M <input type="checkbox"/> NM <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> SF | BREED<br><i>DSH</i> | DESCRIPTION<br><i>Blk White</i> |                          |
| ABNORMALITIES OR IDIOSYNCRASIES                                                                                                            |                     | DIET                            |                          |

COMMENTS  
*LHS Adoption*

☒ Indoor ☐ Outdoor ☐ Show

| VACCINES | RABIES   | 11/1/02       | 10/1/03 | 10/1/04 | 1-23-06 |         |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------|----------|---------------|---------|---------|---------|---------|--|--|--|--|--|--|--|--|--|--|--|--|--|
|          | FVR-CP-C | 10-16-02      | 11/1/03 | 10/1/03 | 11/01   | 1-23-06 |  |  |  |  |  |  |  |  |  |  |  |  |  |
|          | FelV     | 11/1/04       | 1-23-06 |         |         |         |  |  |  |  |  |  |  |  |  |  |  |  |  |
|          | FIP      |               |         |         |         |         |  |  |  |  |  |  |  |  |  |  |  |  |  |
|          | SERVICES | LEUKEMIA TEST |         |         |         |         |  |  |  |  |  |  |  |  |  |  |  |  |  |
|          | FECAL    |               |         |         |         |         |  |  |  |  |  |  |  |  |  |  |  |  |  |
|          | DENTAL   |               |         |         |         |         |  |  |  |  |  |  |  |  |  |  |  |  |  |

| PROBLEM LIST | MEDICATIONS | ALLERGIES |
|--------------|-------------|-----------|
|              |             |           |
|              |             |           |
|              |             |           |
|              |             |           |
|              |             |           |

| DATE            | TREATMENT NOTES                                                    | WEIGHT/TEMP  |
|-----------------|--------------------------------------------------------------------|--------------|
| <i>10/30/02</i> | <i>RFV. Free LHS Adoption Exam. Evaluate upper Resp congestion</i> | <i>13/4</i>  |
|                 | <i>bloody nasal discharge x 2 days</i>                             |              |
|                 | <i>FVRCP on 10/16. Eating &amp; drinking, activity slightly ↓.</i> |              |
|                 | <i>FELV (neg) at other vet - deformed also.</i>                    |              |
|                 | <i>URI ~ 10 day duration H+LOK</i>                                 |              |
|                 | <i>got better then worse again.</i>                                |              |
|                 | <i>Sneezing - M/P nasal d/c - w/ blood.</i>                        |              |
|                 | <i>Rx - clavamox 1/2 dropperful BID</i>                            |              |
| <i>11-9-02</i>  | <i>No more sneezing</i>                                            |              |
|                 | <i>2nd booster</i>                                                 |              |
|                 | <i>Doing well No ent. l.n. BAR.</i>                                |              |
|                 | <i>Sl. mucousy nasal d/c. No ulcers in mouth.</i>                  |              |
|                 | <i>ear mites</i>                                                   |              |
|                 | <i>Acarveyx 1x</i>                                                 |              |
| <i>12-20-02</i> | <i>Final Booster FVRCP</i>                                         | <i>3.75#</i> |
|                 | <i>eating well. BAR</i>                                            |              |
|                 | <i>just finished ALBON still having loose stools</i>               |              |
|                 | <i>Abax, no ent. l.n.; good haircoat.</i>                          |              |

Serial No. 10275

MERIAL Diluent 5

Serial No. 64127  
Exp. Date 30OCT03

MERIAL RCP- 5

Serial No. 17044  
Exp. Date 11APR03

MERIAL Rabies 5

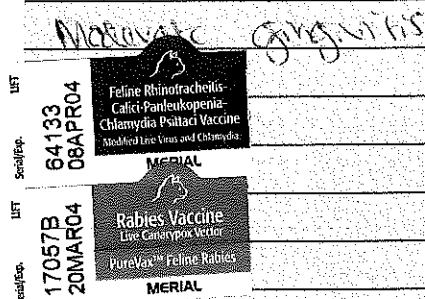
Serial No. 641258  
Exp. Date 26SEP03

MERIAL RCP- 5

| DATE    | TREATMENT NOTES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | WEIGHT/TEMP                                                                                                                                                    |
|---------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3/10/03 | <b>SURGICAL SUMMARY</b><br>Name: <u>Maggie</u> Date: <u>3/10/03</u><br>Procedure: <u>Spay</u> Lab: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>Pre-Anesthesia: <u>Telazol 0.9 ml</u> X-rays: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>Induction: _____<br>Anesthesia: <u>ISO</u> Time: <u>11:15 am</u><br>Monitor System: <u>Visual</u><br>Fluids: _____<br>Closure: Musc. _____ Periton. _____<br>Subq. _____ Skin _____<br>Surgical Observation: _____<br>Surgeon: <u>ATB</u> Asst. _____ | 4 1/2 L-OK<br>5 1/4 #<br>3 OPDS on pedicles<br>& stump. Modified<br>Miller's Knots & transfix lig.<br>respectively.<br>3 layer closure.<br>Scscl. intradermal. |

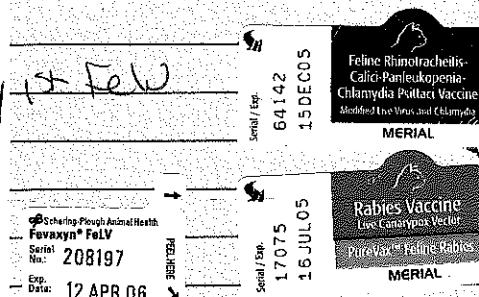
10/16/03 FURCP, RV

| PHYSICAL EXAM CHECKLIST                                                                                      |                                                                                                            |                                                                                                            |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| Name _____                                                                                                   |                                                                                                            | Owner _____                                                                                                |                                                                                                       |
| Diet _____                                                                                                   |                                                                                                            | Vax <u>FURCP, RV</u>                                                                                       |                                                                                                       |
| Fecal _____                                                                                                  |                                                                                                            | Heartworm _____                                                                                            |                                                                                                       |
| <b>General Appearance</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Integumentary</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal    | <b>Musculo-Skeletal</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Circulatory</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal |
| <b>Respiratory</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Digestive</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Genito-Urinary</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal   | BT _____<br>HR <u>110</u><br>RR _____<br>WT _____                                                     |
| <b>Eyes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal               | <b>Ears</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal             | <b>Neural System</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal    |                                                                                                       |
| <b>Lymph Nodes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Mucous Membranes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Dental</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal           |                                                                                                       |



10/5/04 Maggie - FURCP / RV P. way / Feb 1st

| PHYSICAL EXAM CHECKLIST                                                                                      |                                                                                                            |                                                                                                            |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| Name: <u>Maggie</u>                                                                                          |                                                                                                            | Owner: <u>Cox</u>                                                                                          |                                                                                                       |
| Diet: _____                                                                                                  |                                                                                                            | Vax: <u>FURCP / RV P. way / Feb 1st</u>                                                                    |                                                                                                       |
| Fecal: _____                                                                                                 |                                                                                                            | Heartworm: _____                                                                                           |                                                                                                       |
| <b>General Appearance</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Integumentary</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal    | <b>Musculo-Skeletal</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Circulatory</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal |
| <b>Respiratory</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Digestive</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Genito-Urinary</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal   | BT _____<br>HR _____<br>RR _____<br>WT _____                                                          |
| <b>Eyes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal               | <b>Ears</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal             | <b>Neural System</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal    |                                                                                                       |
| <b>Lymph Nodes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Mucous Membranes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Dental</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal           |                                                                                                       |



Mortovate taykov.

11 1/2 #

| DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | FELINE TREATMENT NOTES                                                    |                                           |                                           |  | WEIGHT/TEMP |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
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| 1/23/06                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | FVRCP, RV, FeLV                                                           |                                           |                                           |  | 11 1/2 #    |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
| <table border="1"> <thead> <tr> <th colspan="2">PHYSICAL EXAM</th> <th>Pet:</th> <th colspan="2">Date:</th> </tr> </thead> <tbody> <tr> <td>General Appearance</td> <td>Integumentary</td> <td>Musculo-Skeletal</td> <td colspan="2">Circulatory</td> </tr> <tr> <td><input type="checkbox"/> Normal <b>1</b></td> <td><input type="checkbox"/> Normal <b>2</b></td> <td><input type="checkbox"/> Normal <b>3</b></td> <td colspan="2"><input type="checkbox"/> Normal <b>4</b></td> </tr> <tr> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td colspan="2"><input type="checkbox"/> Abnormal</td> </tr> <tr> <td></td> <td><input type="checkbox"/> No Exam</td> <td><input type="checkbox"/> No Exam</td> <td colspan="2"><input type="checkbox"/> No Exam</td> </tr> <tr> <td>Respiratory</td> <td>Digestive</td> <td>Genito-Urinary</td> <td colspan="2">Eyes</td> </tr> <tr> <td><input type="checkbox"/> Normal <b>5</b></td> <td><input type="checkbox"/> Normal <b>6</b></td> <td><input type="checkbox"/> Normal <b>7</b></td> <td colspan="2"><input type="checkbox"/> Normal <b>8</b></td> </tr> <tr> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td colspan="2"><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> No Exam</td> <td><input type="checkbox"/> No Exam</td> <td><input type="checkbox"/> No Exam</td> <td colspan="2"><input type="checkbox"/> No Exam</td> </tr> <tr> <td>Ears</td> <td>Neural Systems</td> <td>Lymph Nodes</td> <td colspan="2">Mucous Membranes</td> </tr> <tr> <td><input type="checkbox"/> Normal <b>9</b></td> <td><input type="checkbox"/> Normal <b>10</b></td> <td><input type="checkbox"/> Normal <b>11</b></td> <td colspan="2"><input type="checkbox"/> Normal <b>12</b></td> </tr> <tr> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Abnormal</td> <td colspan="2"><input type="checkbox"/> Abnormal</td> </tr> <tr> <td><input type="checkbox"/> No Exam</td> <td><input type="checkbox"/> No Exam</td> <td><input type="checkbox"/> No Exam</td> <td colspan="2"><input type="checkbox"/> No Exam</td> </tr> <tr> <td>Dental</td> <td colspan="4">Describe ABNORMAL using the numbers above:</td> </tr> <tr> <td><input type="checkbox"/> Normal <b>13</b></td> <td colspan="4">T _____ P _____ R _____ Wt _____</td> </tr> <tr> <td><input type="checkbox"/> Abnormal</td> <td colspan="4">Notes: _____ <input type="checkbox"/> Scale <input type="checkbox"/> Est.</td> </tr> <tr> <td><input type="checkbox"/> No Exam</td> <td colspan="4"></td> </tr> </tbody> </table> |                                                                           |                                           |                                           |  |             | PHYSICAL EXAM |  | Pet: | Date: |  | General Appearance | Integumentary | Musculo-Skeletal | Circulatory |  | <input type="checkbox"/> Normal <b>1</b> | <input type="checkbox"/> Normal <b>2</b> | <input type="checkbox"/> Normal <b>3</b> | <input type="checkbox"/> Normal <b>4</b> |  | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal |  |  | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam |  | Respiratory | Digestive | Genito-Urinary | Eyes |  | <input type="checkbox"/> Normal <b>5</b> | <input type="checkbox"/> Normal <b>6</b> | <input type="checkbox"/> Normal <b>7</b> | <input type="checkbox"/> Normal <b>8</b> |  | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal |  | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam |  | Ears | Neural Systems | Lymph Nodes | Mucous Membranes |  | <input type="checkbox"/> Normal <b>9</b> | <input type="checkbox"/> Normal <b>10</b> | <input type="checkbox"/> Normal <b>11</b> | <input type="checkbox"/> Normal <b>12</b> |  | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal |  | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam | <input type="checkbox"/> No Exam |  | Dental | Describe ABNORMAL using the numbers above: |  |  |  | <input type="checkbox"/> Normal <b>13</b> | T _____ P _____ R _____ Wt _____ |  |  |  | <input type="checkbox"/> Abnormal | Notes: _____ <input type="checkbox"/> Scale <input type="checkbox"/> Est. |  |  |  | <input type="checkbox"/> No Exam |  |  |  |  |
| PHYSICAL EXAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                           | Pet:                                      | Date:                                     |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
| General Appearance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Integumentary                                                             | Musculo-Skeletal                          | Circulatory                               |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
| <input type="checkbox"/> Normal <b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Normal <b>2</b>                                  | <input type="checkbox"/> Normal <b>3</b>  | <input type="checkbox"/> Normal <b>4</b>  |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
| <input type="checkbox"/> Abnormal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Abnormal                                         | <input type="checkbox"/> Abnormal         | <input type="checkbox"/> Abnormal         |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
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| Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Digestive                                                                 | Genito-Urinary                            | Eyes                                      |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
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| Ears                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Neural Systems                                                            | Lymph Nodes                               | Mucous Membranes                          |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
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| Dental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Describe ABNORMAL using the numbers above:                                |                                           |                                           |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
| <input type="checkbox"/> Normal <b>13</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | T _____ P _____ R _____ Wt _____                                          |                                           |                                           |  |             |               |  |      |       |  |                    |               |                  |             |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |  |                                  |                                  |                                  |  |             |           |                |      |  |                                          |                                          |                                          |                                          |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |      |                |             |                  |  |                                          |                                           |                                           |                                           |  |                                   |                                   |                                   |                                   |  |                                  |                                  |                                  |                                  |  |        |                                            |  |  |  |                                           |                                  |  |  |  |                                   |                                                                           |  |  |  |                                  |  |  |  |  |
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                |  |             | PHYSICAL EXAM |  | Name: | Date: |  | General Appearance | Integumentary | Musculo-Skeletal | Circulatory |  | <input checked="" type="checkbox"/> Normal <b>1</b> | <input checked="" type="checkbox"/> Normal <b>2</b> | <input checked="" type="checkbox"/> Normal <b>3</b> | <input checked="" type="checkbox"/> Normal <b>4</b> |  | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal |  |  | <input type="checkbox"/> Exam | <input type="checkbox"/> Exam | <input type="checkbox"/> Exam |  | Respiratory | Digestive | Genito-Urinary | Eyes |  | <input checked="" type="checkbox"/> Normal <b>5</b> | <input checked="" type="checkbox"/> Normal <b>6</b> | <input checked="" type="checkbox"/> Normal <b>7</b> | <input checked="" type="checkbox"/> Normal <b>8</b> |  | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Abnormal | <input 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| PHYSICAL EXAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| General Appearance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Integumentary                                                             | Musculo-Skeletal                                     | Circulatory                                          |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input checked="" type="checkbox"/> Normal <b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input checked="" type="checkbox"/> Normal <b>2</b>                       | <input checked="" type="checkbox"/> Normal <b>3</b>  | <input checked="" type="checkbox"/> Normal <b>4</b>  |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |                               |                               |                               |                               |  |      |                |             |                  |  |                                                     |                                                      |                                                      |                                                      |  |                                   |                                   |                                   |                                   |  |                               |                               |                               |                               |  |        |                                            |  |  |  |                                           |                                       |  |  |  |                                              |                                                                           |  |  |  |                               |  |  |  |  |
| <input type="checkbox"/> Abnormal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input checked="" type="checkbox"/> Normal <b>5</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input checked="" type="checkbox"/> Normal <b>6</b>                       | <input checked="" type="checkbox"/> Normal <b>7</b>  | <input checked="" type="checkbox"/> Normal <b>8</b>  |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |              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|  |                               |  |  |  |  |
| <input type="checkbox"/> Abnormal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input type="checkbox"/> Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| Ears                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input checked="" type="checkbox"/> Normal <b>9</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input checked="" type="checkbox"/> Normal <b>10</b>                      | <input checked="" type="checkbox"/> Normal <b>11</b> | <input checked="" type="checkbox"/> Normal <b>12</b> |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |              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|  |                               |  |  |  |  |
| <input type="checkbox"/> Abnormal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Abnormal                                         | <input type="checkbox"/> Abnormal                    | <input type="checkbox"/> Abnormal                    |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input type="checkbox"/> Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> Exam                                             | <input type="checkbox"/> Exam                        | <input type="checkbox"/> Exam                        |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| Dental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Describe Abnormal using the numbers above:                                |                                                      |                                                      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input type="checkbox"/> Normal <b>13</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | T _____ P <u>130</u> R _____ Wt _____                                     |                                                      |                                                      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                  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                              |  |  |  |  |
| <input checked="" type="checkbox"/> Abnormal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Notes: _____ <input type="checkbox"/> Scale <input type="checkbox"/> Est. |                                                      |                                                      |  |             |               |  |       |       |  |                    |               |                  |             |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |  |                               |                               |                               |  |             |           |                |      |  |                                                     |                                                     |                                                     |                                                     |  |                                   |                                   |                                   |                                   |  |                               |                               |                               |                               |  |      |                |             |                  |  |                                                     |                                                      |                                                      |                                                      |  |                                   |                                   |                                   |                                   |  |                               |                               |                               |                               |  |        |                                            |  |  |  |                                           |                                       |  |  |  |                                              |                                                                           |  |  |  |                               |  |  |  |  |
| <input type="checkbox"/> Exam                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| <div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| Date | Date | Date | Date |
|------|------|------|------|
|      |      |      |      |
|      |      |      |      |

| DATE    | FELINE TREATMENT NOTES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | WEIGHT/TEMP |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 4/30/08 | <p>Attacked by dog? other? Several abrasions dorsally. Deep laceration <sup>down</sup> to muscle layer</p> <p>Ⓢ RQ ventral thorax</p> <p>H+L OK - No Xray taken ISO mask</p> <p><del>Placed</del> Placed drain in ventral laceration.</p> <p>Dorsal bruising in 4 places - Debrided tissue assoc. w/ @ shoulder - debrided + placed another drain.</p> <p>Other areas have a better chance of healing, however</p> <p>Ice PPG S O A may need debridement in future</p> <p>0.3ml Metacam S O A</p> <p>Rx Clindamycin 1 drop per 1 BID</p> <p>Rx Metacam 0.5mg/ml Give 2 lb dose once daily as needed for pain</p> <p>Drain removal in 3-6 days, s/R 14 days</p> | 11 1/2 #    |

5/15/08 Maggie - Junds

Suture reactions + dehiscing + necrotic fat + tissue → reopened wounds

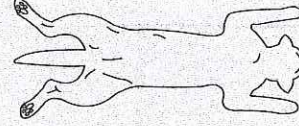
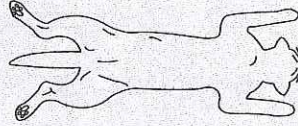
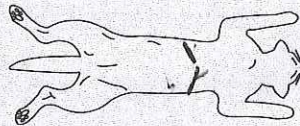
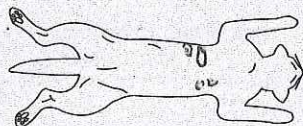
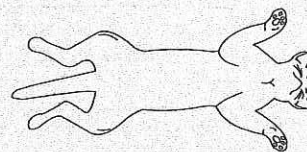
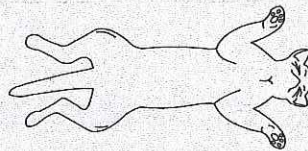
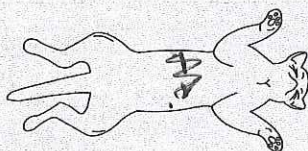
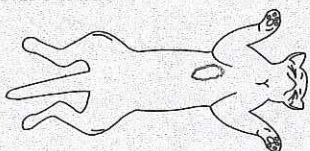
de removed as much dead tissue as could be found - freshened → over.

| SURGICAL SUMMARY                   |                                                                             |
|------------------------------------|-----------------------------------------------------------------------------|
| Name <u>Maggie</u>                 | Date: <u>5/15</u>                                                           |
| Procedure _____                    | Lab: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| Pre-Anesthesia _____               | X-rays: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Induction <u>0.18 ml torazodim</u> |                                                                             |
| Anesthesia <u>ISO</u>              | Time _____                                                                  |
| Monitor System <u>V. Sured</u>     |                                                                             |
| Fluids _____                       |                                                                             |
| Closure: Musc. _____               | Periton _____                                                               |
| Subq. _____                        | Skin _____                                                                  |
| Surgical Observation _____         |                                                                             |
| Surgeon <u>SB</u>                  | Asst. _____                                                                 |

Date 4-30-08

Date 5-15

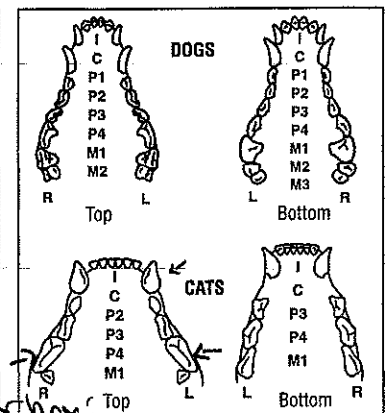
HR 140



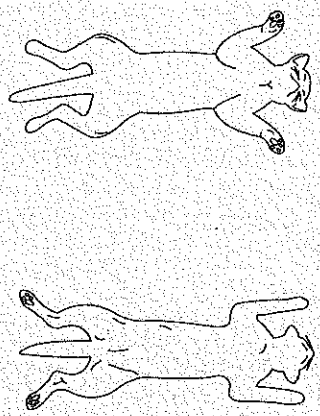
| DATE    | FELINE TREATMENT NOTES                                                                                                                                                                                | WEIGHT/TEMP |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 5-15-08 | cont - 2 edges & bases as much as possible<br>Placed 3 penrose drains<br>Closed all w/ 3-0 Ethicon<br>remove in 3-5 days<br>Rx Metronidazole 100mg #7 1 tablet SID<br>Metacam po pm 0.5ml ID pm po ID |             |
| 5-16-08 | Ch wounds Am ID / Flagyl po pm ID<br>ate / drank pm urine NO But                                                                                                                                      |             |
| 5-17-08 | drank a little, did not eat<br>- urine 1 - BM<br>Metronidazole 250mg pm ID                                                                                                                            |             |
| 5-18-08 | metronidazole ID pm<br>eating some, urine + 1 - BM                                                                                                                                                    |             |
| 5-19-08 | urine / But eating pm Flagyl 100mg po pm ID<br>removed drains ID / ch wounds ID                                                                                                                       |             |
| 5-20-08 | Flagyl 100mg po pm ID / urine NO But eating canned pa                                                                                                                                                 |             |
| 5-27-08 | re suture, dental                                                                                                                                                                                     | 10 1/2 /    |

| SURGICAL SUMMARY                  |                               |
|-----------------------------------|-------------------------------|
| Name <u>Maggie</u>                | Date <u>5/27</u>              |
| Procedure <u>Removal</u>          | Lab: YES NO<br>X-rays: YES NO |
| Pre-Anesthesia                    |                               |
| Induction <u>O. K. Telazol IM</u> |                               |
| Anesthesia <u>T. S. inhaled</u>   | Time                          |
| Monitor System <u>Pulse Ox</u>    |                               |
| Fluids                            |                               |
| Closure: Musc. Periton            |                               |
| Subq. Skin                        |                               |
| Surgical Observation              |                               |
| Surgeon                           | Asst.                         |

| DENTAL EXAMINATION                                                                                                                                                                      |                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Name <u>Maggie</u>                                                                                                                                                                      | Date <u>5/27</u> |
| <input type="checkbox"/> Indicates Displaced Tooth<br><input checked="" type="checkbox"/> Indicates Missing Tooth<br><input checked="" type="checkbox"/> Indicates Caries, Injury, etc. |                  |
| 1.                                                                                                                                                                                      |                  |
| 2.                                                                                                                                                                                      |                  |
| 3.                                                                                                                                                                                      |                  |
| 4.                                                                                                                                                                                      |                  |
| Gingiva <u>Stage I</u>                                                                                                                                                                  |                  |
| Occlusion <u>Normal</u>                                                                                                                                                                 |                  |
| Salivation <u>normal</u>                                                                                                                                                                |                  |
| Halitosis: YES <u>NO</u> (circle one)                                                                                                                                                   |                  |
| Periodontal Disease <u>none</u>                                                                                                                                                         |                  |
| Other: <u>sensitive but no</u>                                                                                                                                                          |                  |
| <u>flushed w/ chlorhex</u>                                                                                                                                                              |                  |



Excised cellulitis & infected tissue  
Placed penrose drain & closed in 2 layers  
3-0 PDS SCI / S closures.  
Rx: Antibiotic 1ml BID  
5/28/08 - Pass reabsorption - small nodules near incisions.  
Rx Metronidazole 100mg 1 Tablet SID #14  
Rx Orban 22.7mg 1T SID #14.



| DATE    | FELINE TREATMENT NOTES | WEIGHT/TEMP |
|---------|------------------------|-------------|
| 6-10-08 | Debride                | 9 1/4#      |

| SURGICAL SUMMARY                         |                                                                             |
|------------------------------------------|-----------------------------------------------------------------------------|
| Name: <u>Maggie</u>                      | Date: <u>6/10/08</u>                                                        |
| Procedure: <u>debride</u>                | Lab: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |
| Pre-Anesthesia: _____                    | X-rays: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Induction: <u>0.18ml Telazol IM</u>      |                                                                             |
| Anesthesia: <u>ISO</u>                   | Time: _____                                                                 |
| Monitor System: <u>Vision / pulse ox</u> |                                                                             |
| Fluids: _____                            |                                                                             |
| Closure: Musc. _____ Periton _____       |                                                                             |
| Subq. _____ Skin _____                   |                                                                             |
| Surgical Observation: <u>ATB</u>         |                                                                             |
| Surgeon: _____                           | Asst. <u>MC</u>                                                             |

Excised large section of firm skin which when squeezed, pus oozes out. Placed penrose drain & sutured using 3-0 PDS S. cruciate pattern.

C&S - aerobic & anaerobic to Antech.

1cc Baytril IM.  
Impression smear (normal).

Histopath of lesions submitted to Pal Path.

Keep until C&S results are in.

Continue w/ ~~Orbax~~ & Metronidazole.

\*very slow waking up from anesthesia.

6-11-08 doing well in am Gave small amount FOOD & WATER

6-12-08 metron ~~or~~ orbax ~~or~~ eating + drinking urine in box

6-14-08 According to C&S d/e other med

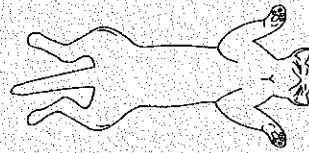
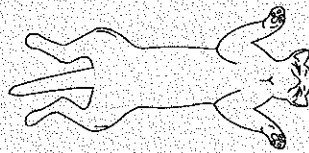
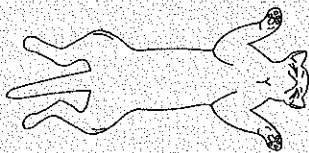
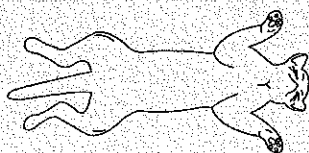
Rx Clavamox 1 drop per pill BID ~~or~~

Date 6/10/08

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_



| DATE    | FELINE TREATMENT NOTES                                                                             | WEIGHT/TEMP |
|---------|----------------------------------------------------------------------------------------------------|-------------|
| 7/14/08 | not eating for 2 days. seems tender @ original<br>sx site.<br>cel <del>ST</del> / CBC <del>✓</del> | 7 1/2 #     |
|         | FelW (-) Faw (-)                                                                                   |             |

| SURGICAL SUMMARY                           |                                                                             |
|--------------------------------------------|-----------------------------------------------------------------------------|
| Name <u>Maggie</u>                         | Date <u>7/14/08</u>                                                         |
| Procedure <u>Resection</u>                 | Lab: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |
| Pre-Anesthesia <u>Sevoflurane</u>          | X-rays: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Induction <u>Sevoflurane</u>               |                                                                             |
| Anesthesia <u>Sevoflurane</u>              | Time <u>1:30</u>                                                            |
| Monitor System <u>Vizual</u>               |                                                                             |
| Fluids                                     |                                                                             |
| Closure: Musc. <u>                    </u> | Periton <u>                    </u>                                         |
| Subq. <u>                    </u>          | Skin <u>                    </u>                                            |
| Surgical Observation                       |                                                                             |
| Surgeon <u>ATB</u>                         | Asst. <u>                    </u>                                           |

Large - egg sized mass  
in @ axilla.

Ca. 5 to Antech X2

0.34 (concentrations) SP

Rx Meloxicam 100mg #7 - 15 in  
pm

|         |                                                                                                   |         |
|---------|---------------------------------------------------------------------------------------------------|---------|
| 7/15/08 | pm Flagyl 100mg po <del>✓</del> urine / Bu / eating<br>Drainage & fair amt.                       |         |
| 7/17/08 | urine / Bu / eating drinking good pm 100mg Flagyl po <del>✓</del>                                 |         |
| 7/19/08 | urine / Bu / eating / some drainage 100mg Flagyl po pm <del>✓</del><br>removed drain / cheek ends |         |
| 7/21/08 | urine / Bu / eating undigested - <del>✓</del><br>100mg Flagyl pm po <del>✓</del> QAR.             | 7 1/2 # |

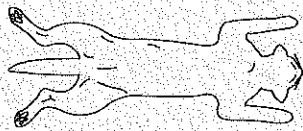
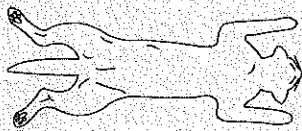
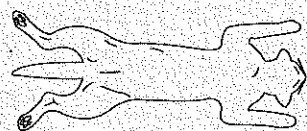
| SURGICAL SUMMARY                           |                                                                             |
|--------------------------------------------|-----------------------------------------------------------------------------|
| Name <u>Maggie</u>                         | Date <u>7/21/08</u>                                                         |
| Procedure <u>Resection side</u>            | Lab: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |
| Pre-Anesthesia <u>Sevoflurane</u>          | X-rays: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Induction <u>Sevoflurane</u>               |                                                                             |
| Anesthesia <u>Sevoflurane</u>              | Time <u>                    </u>                                            |
| Monitor System <u>Vizual</u>               |                                                                             |
| Fluids                                     |                                                                             |
| Closure: Musc. <u>                    </u> | Periton <u>                    </u>                                         |
| Subq. <u>                    </u>          | Skin <u>                    </u>                                            |
| Surgical Observation                       |                                                                             |
| Surgeon <u>ATB</u>                         | Asst. <u>                    </u>                                           |

Rx #7 Flagyl 100mg - 15 in

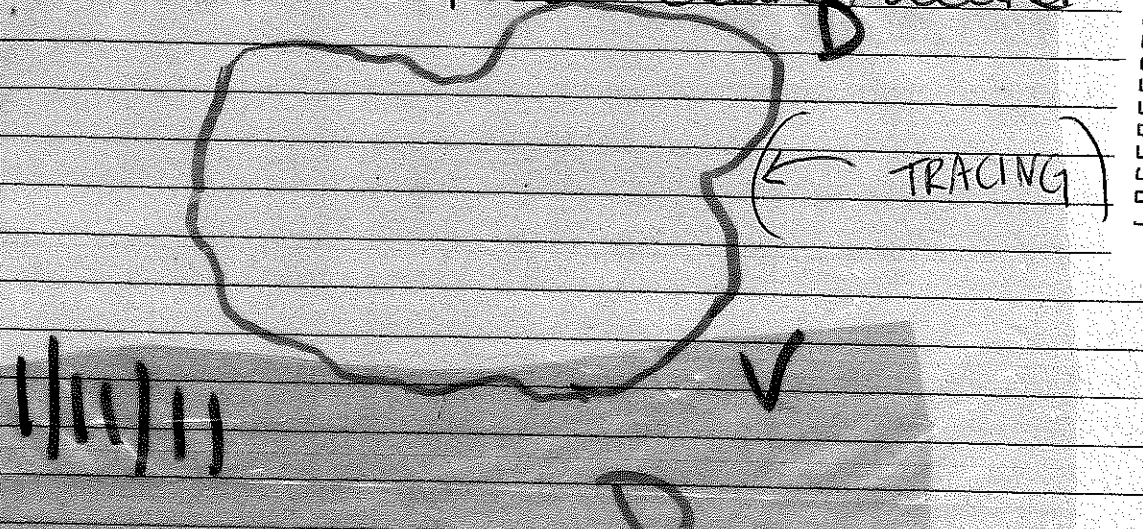
FelW / Faw / Faw sample to  
Antech

Rx Clavox - date BIRs and  
Debrided & replaced a peritoneal  
drain, closed w/ 3-0 nylon  
Suture pattern.

→ evidence of likely new lesions.  
→ if neg on FIP - consider referral  
or BIR box.



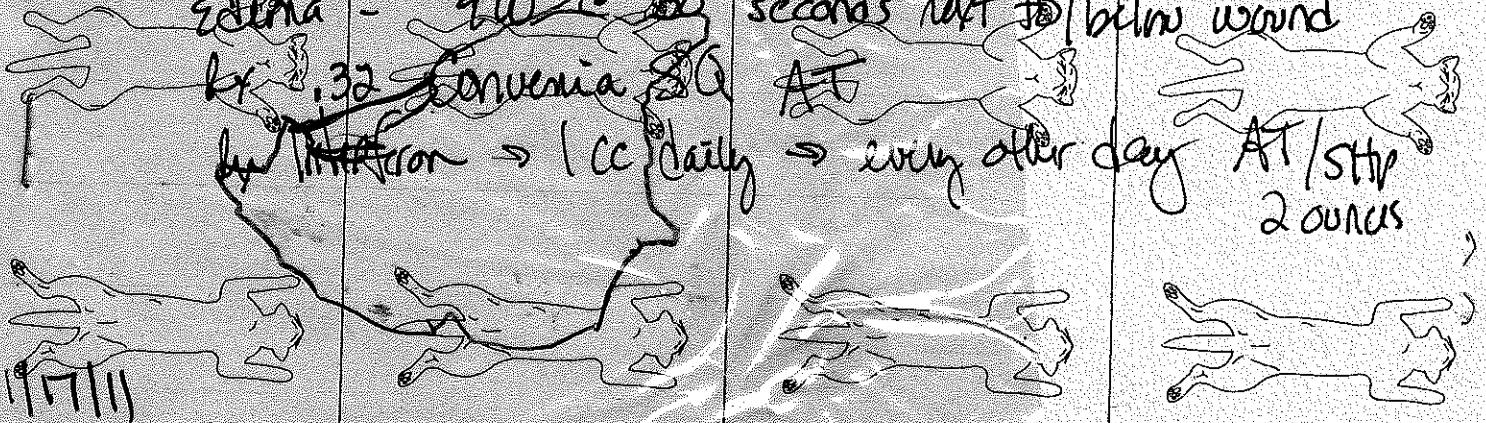


| DATE    | FELINE TREATMENT NOTES                                                                                                                                | WEIGHT/TEMP            |
|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| 1-11-11 | Laser treatment for wound<br>masked down w/ ISO + cleaned wound<br> | 7 1/2#<br>A70203383589 |
| Laser   | 9W 30 seconds wound 30 seconds spine<br>9W 1 min spine x 2                                                                                            |                        |
| 1-14-11 | Laser therapy<br>wound - 9W at 30 sec granulation tissue<br>spine - 9W at 1 min on each side                                                          |                        |

1-17-11 Laser therapy

|         |                                     |      |
|---------|-------------------------------------|------|
| wound - | Date 9W @ 30 seconds                | Date |
| spine - | 9W @ 1 min each side                |      |
| edema - | 9W @ 30 seconds next to/below wound |      |

Rx: 32 Fenugreek 30 AT  
 for infection → 1 cc daily → every other day AT/STP 2 ounces



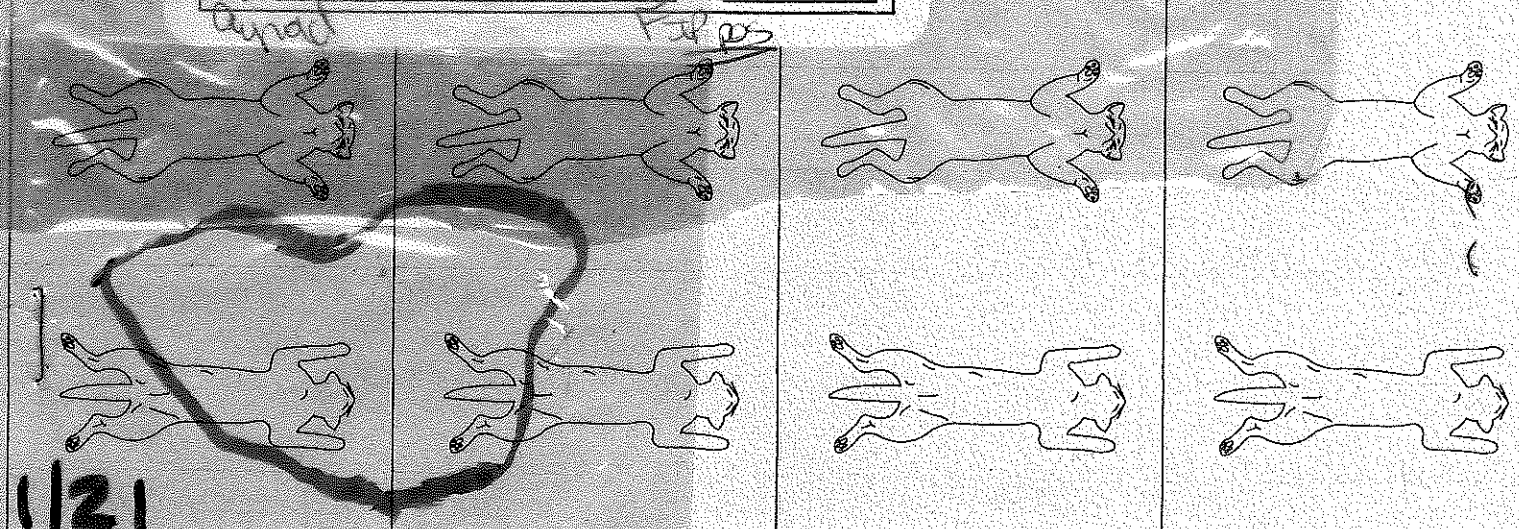
| DATE     | FELINE TREATMENT NOTES                                                                                                                                                               | WEIGHT/TEMP |
|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 11/17/11 | Per laser les - if edema has increased, dq laser + figure out what's causing edema; otherwise:<br>Recommends adding 1 min of laser @ 10W to hind leg + upwards to cover swelling.    |             |
| 11/18/11 | No clear edema, suspect 20% wound contraction (artifact). No laser today.<br>Regular laser session tomorrow, will also drop off Thuis p.m for sk to debride & laser on Friday. (0.8) |             |

|          |                                                           |       |
|----------|-----------------------------------------------------------|-------|
| 1-20-11  | Laser therapy wound 9W 30 sec<br>Spine 9W 1 min each side | 7.75# |
| 11/21/11 | Sedate / debride / laser                                  | 7.75# |

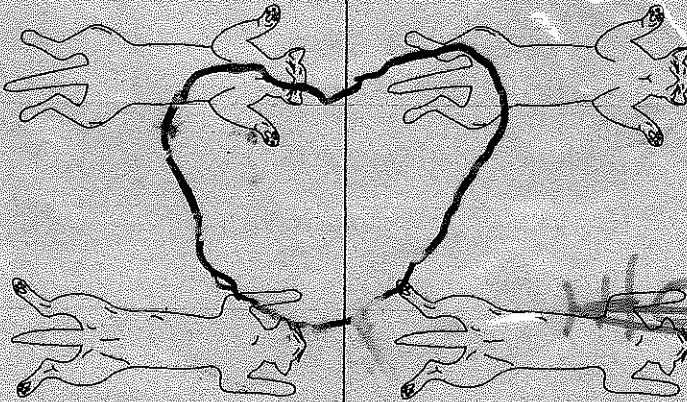
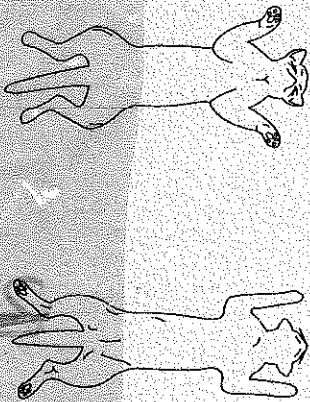
**SURGICAL SUMMARY**

Name: Maggie Cat Lab: 11/11/11  
 Procedure: Debride wound Lab: 11/20/11  
 Pre-Anesthesia: Sed X-rays: Yes  
 Induction: Sed  
 Anesthesia: Sed Time: 2:30pm  
 Monitor System: Pulse ox / V. sat  
 Fluids: \_\_\_\_\_  
 Closure: Musc. \_\_\_\_\_ Periton. \_\_\_\_\_  
 Subq. \_\_\_\_\_ Skin \_\_\_\_\_  
 Surgical Observation: \_\_\_\_\_  
 Surgeon: \_\_\_\_\_ Asst. \_\_\_\_\_

1-20-11



| DATE     | FELINE TREATMENT NOTES                                                            | WEIGHT/TEMP |
|----------|-----------------------------------------------------------------------------------|-------------|
| 9/30/11  | Laser wound + spine ① 9w 30 sec ② 9w 1m/each side                                 | SD          |
|          |  |             |
| 11/31/11 |                                                                                   |             |
| 2-10-11  | Laser wound + spine ① 9w 30 sec ② 9w 1m/x 2 SD                                    |             |

|                                                                                                  |                                                                                                            |                                                                                                    |                                                                                                     |
|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Date _____<br> | Date <u>2/10/11</u><br> | Date _____<br> | Date _____<br> |
|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|

2/18/11

No significant A  
Plan to sedate next wk  
Debride & suture

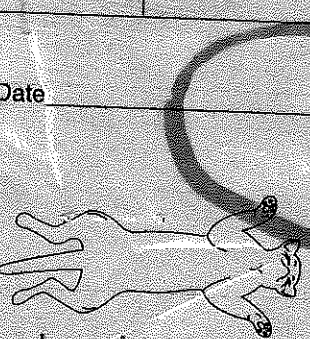
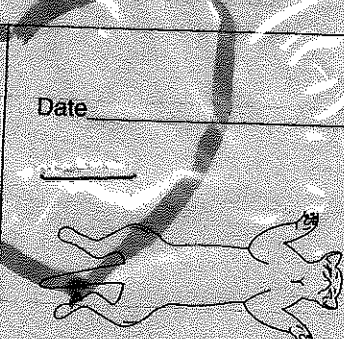
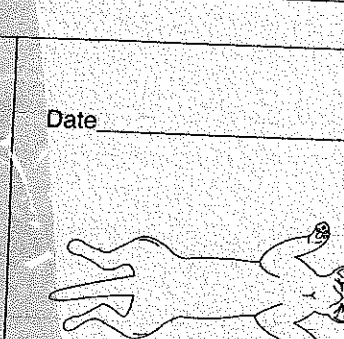
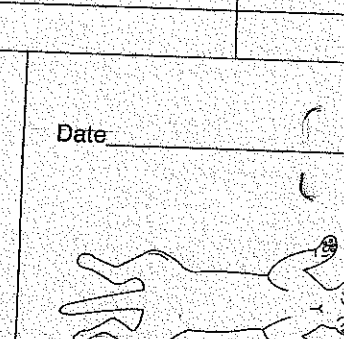
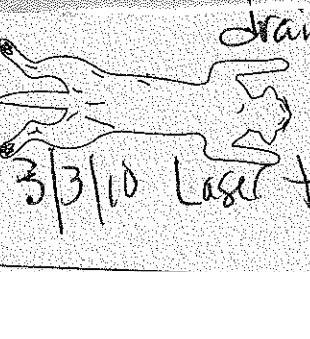
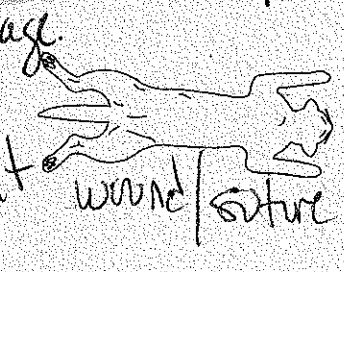
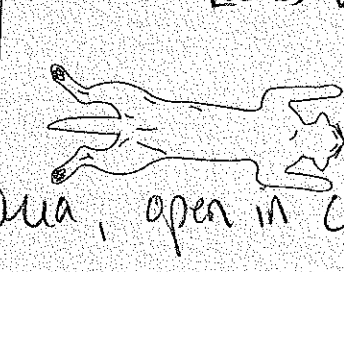
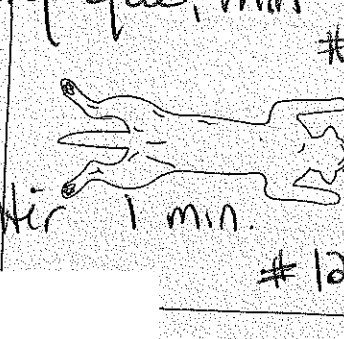
Go back to 2x6w tx

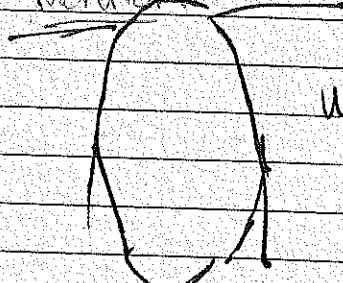
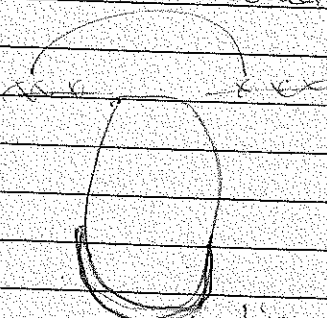
laser tx wound 9w @ 30 sec  
laser spray 9w @ 1 min each side

Baked @ 560. - Debrided wound - fair amt  
of scar tissue (keratins). Undermined the skin &  
closed fl each corner. 3-0 Vicryl ST pattern.

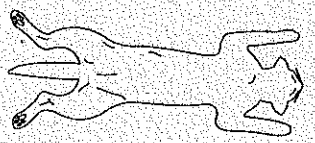
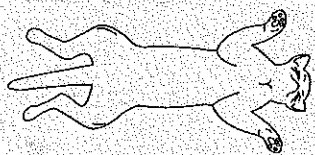
Laser. 9w @ 1 min. - Rec laser eod. x 2 wks.

2/24/11 laser 9w @ 1 min wound

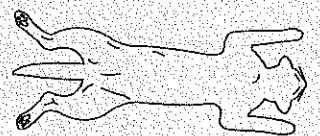
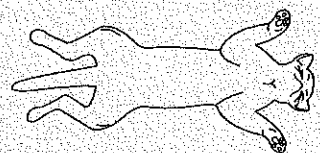
| Date                                                                               | Date                                                                                | Date                                                                                 | Date                                                                                  |
|------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
|  |  |  |  |
| 2/28/10 Laser tx wound/suture area. Looks very good, min drainage.                 |                                                                                     |                                                                                      |                                                                                       |
|  |  |  |  |
| 3/3/10 Laser tx wound/suture area, open in center 1 min.                           |                                                                                     |                                                                                      | #11                                                                                   |
|                                                                                    |                                                                                     |                                                                                      | #12                                                                                   |

| DATE    | FELINE TREATMENT NOTES                                                                                                                                                                                                                                                                                                                                                                                                               | WEIGHT/TEMP |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|
| 3/3/11  | <p>to brought in wound has open<br/> gave D.34 Convenia inj <input checked="" type="checkbox"/> SO<br/> removed stitches that were not attached<br/> cleaned with chlorhexi Sol.<br/> Laser <input checked="" type="checkbox"/></p> <p>Overall looks good. Some superficial excoriations<br/> involving dorsal aspect of wound (where hair was<br/> clipped). Suspect scratching (self mutilation)<br/> or clipper burn. Monitor</p> |             |
| 3/7/11  | <p>Laser # 2 of 6<br/> 1 min spine x 2<br/> 30 sec wound</p>  <p>Wound size increased</p>                                                                                                                                                                                                                                                           |             |
| 3/10/11 | <p>Healed</p>  <p>Wound at 9w x 60sec<br/> Left side spine 12w x 1 min</p> <p>Pick d/c laser for luk<br/> then restart.</p> <p>Rx: compressive FLD</p> <p>lip of epithelialization.<br/> Healed</p>                                                                                                                                                |             |

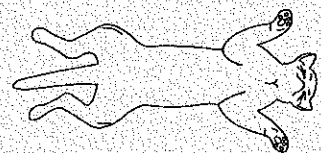
Date \_\_\_\_\_



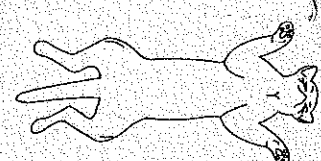
Date \_\_\_\_\_



Date \_\_\_\_\_



Date \_\_\_\_\_



| DATE    | FELINE TREATMENT NOTES                                        | WEIGHT/TEMP |
|---------|---------------------------------------------------------------|-------------|
| 3-17-11 | Laser #3, wound 30 sec. 9W<br>Spine 1 min x 2                 | C#          |
|         | 0.4ml Canine SQ <del>W</del> AST                              |             |
| 3/17/11 |                                                               |             |
| 3/24/11 | Laser #4 <sup>100%</sup> wound 30 sec; Spine 1 min x 2; 9W 9# |             |
| 3/28/11 | Laser #5 <sup>100%</sup> wound 30 sec; Spine 1 min x 2; 9W 9# |             |
|         | Natural                                                       |             |
| 3/28/11 |                                                               |             |

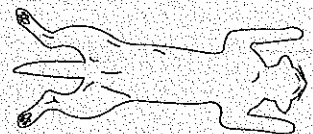
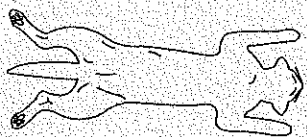
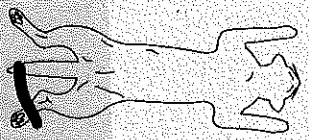
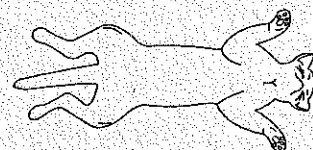
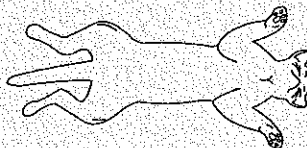
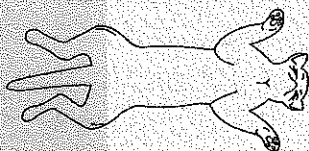
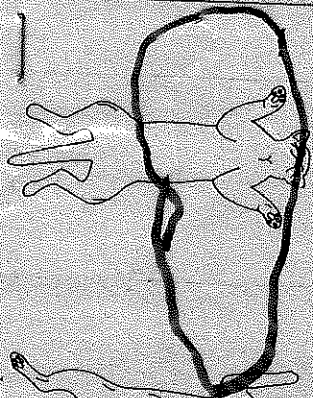
Date

Date

3/31/11 - looks great. Contracting side to side.

Date

Date



3/31/11

1-11 Laser Ce of 4

↑ 4-4-11 Laser Ce of 10; looks better, hair growing on lower end! Clinically - doing great.

4-11-11 Laser tx 2 months 1mm spine wound 7 of 10

(note: adjusted invoice to 10 tx)



4/4/11



4/11/11

5-19-11 Laser tx; amazing healing! 1mm Spine; 3D sc 8 of 10 wound



5-19-11

6/2/11 cont'd

**PHYSICAL EXAM CHECKLIST**

Name \_\_\_\_\_ Owner \_\_\_\_\_  
 Diet \_\_\_\_\_ Vax \_\_\_\_\_  
 Fecal \_\_\_\_\_ Heartworm \_\_\_\_\_

|                                                                                                              |                                                                                                         |                                                                                                            |                                                                                            |
|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>General Appearance</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Integumentary</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Musculo-Skeletal</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal | <b>Circulatory</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal |
| <b>Respiratory</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Digestive</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal     | <b>Genito-Urinary</b><br><input type="checkbox"/> Normal<br><input checked="" type="checkbox"/> Abnormal   | BT _____                                                                                   |
| <b>Eyes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal               | <b>Ears</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal                     | <b>Neural System</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal               | HR _____                                                                                   |
| <b>Lymph Nodes</b><br><input checked="" type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal        | <b>Mucous Membranes</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal         | <b>Dental</b><br><input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal                      | RR _____<br>WT 97.8                                                                        |

Wound continues to improve.  
 back/spine doing well.

6/2/11

Plan: Convenia ~~PRN~~ prophylactically. 0.45ml SQX

Reid if concerns.

**Lake Forest Animal Hospital**  
18510 Forest Rd. Forest, VA 24551  
434-385-6468

|                        |                      |
|------------------------|----------------------|
| Patient: MAGGIE        | Doctor: B            |
| Species: Adult Feline  |                      |
| Client: ELIZABETH COOK | Client ID: 3075-6501 |

**Chemistry**

7/14/2008 10:24 AM

VetTest

|      |            |               |  |
|------|------------|---------------|--|
| BUN  | 16. mg/dL  | (16. - 36. )  |  |
| CREA | 1.0 mg/dL  | (0.8 - 2.4 )  |  |
| TP   | 7.0 g/dL   | (5.7 - 8.9 )  |  |
| ALT  | 34. U/L    | (12. - 130. ) |  |
| ALKP | 82. U/L    | (14. - 111. ) |  |
| GLU  | 133. mg/dL | (74. - 159. ) |  |

**Hematology**

7/14/2008 10:11 AM

LaserCyte

|        |                 |                  |  |
|--------|-----------------|------------------|--|
| RBC    | 6.39 M/ $\mu$ L | (5.00 - 10.00 )  |  |
| HCT    | 24.8 %          | (30.0 - 45.0 )   |  |
| HGB    | 8.6 g/dL        | (9.0 - 15.1 )    |  |
| MCV    | 42.0 fL         | (41.0 - 58.0 )   |  |
| MCH    | 13.52 pg        | (12.00 - 20.00 ) |  |
| MCHC   | 32.2 g/dL       | (29.0 - 37.5 )   |  |
| RDW    | 17.1 %          | (17.3 - 22.0 )   |  |
| %RETIC | 0.9 %           |                  |  |
| RETIC  | 55.0 K/ $\mu$ L |                  |  |
| WBC    | K/ $\mu$ L      | (5.50 - 19.50 )  |  |
| %NEU   | 85.8 %          |                  |  |
| %LYM   | 6.9 %           |                  |  |
| %MONO  | 4.1 %           |                  |  |
| %EOS   | 3.1 %           |                  |  |
| %BASO  | 0.1 %           |                  |  |
| NEU    | K/ $\mu$ L      | (2.50 - 12.50 )  |  |
| LYM    | 2.32 K/ $\mu$ L | (0.40 - 6.80 )   |  |
| MONO   | 1.37 K/ $\mu$ L | (0.15 - 1.70 )   |  |
| EOS    | K/ $\mu$ L      | (0.10 - 0.79 )   |  |
| BASO   | 0.05 K/ $\mu$ L | (0.00 - 0.10 )   |  |
| PLT    | 448. K/ $\mu$ L | (175. - 600. )   |  |
| MPV    | 14.15 fL        |                  |  |
| PDW    | 16.3 %          |                  |  |
| PCT    | 0.6 %           |                  |  |

**Lake Forest Animal Hospital**

18510 Forest Rd  
Forest, VA 24551  
Tel: 434-385-6468  
Fax: 434-385-6469

Doctor  
BUDZYN

Owner  
COOK

Pet Name  
MAGGIE

Received  
06/11/2008

Species  
Feline

Breed

Sex  
SF

Pet Age  
16Y

Reported  
06/17/2008 02:16 PM

| Test Requested | Results | Reference Range | Units |
|----------------|---------|-----------------|-------|
|----------------|---------|-----------------|-------|

**CULTURE & SENSITIVITIES**

Source  
Preliminary #1  
Organism #1  
Pasteurella multocida  
Heavy growth

Organism #2  
Enterococcus species  
Heavy growth

Final Report

#1  
Wound  
06/12/2008  
  
  
  
  
  
  
06/13/2008

**CULTURE (ANAEROBIC)**

Source  
Source  
Status  
Organism #1  
No anaerobic bacteria isolated

Wound  
  
Final

**MIC ORGANISM #1**

Organism #1  
Pasteurella multocida

**MIC(UG/ML) TEST RANGE INTERPRETATION**

|                          |        |        |   |
|--------------------------|--------|--------|---|
| Amikacin                 | N/A    | 4-32   | R |
| Amoxicillin              | <=2    | 2-16   | I |
| Ampicillin               | <=2    | 2-16   | I |
| Cephadroxil              | <=4    | 4-16   | S |
| Cefazolin                | <=4    | 4-16   | S |
| Cefoxitin                | <=4    | 4-16   | S |
| Cefpodoxime(Simplicef)   | <=2    | 2-8    | S |
| Ceftiofur                | <=2    | 2-8    | I |
| Cephalexin               | <=4    | 4-16   | S |
| Clavamox                 | <=2    | 2-16   | S |
| Difloxacin (Dicural)     | <=0.25 | 0.25-2 | S |
| Enrofloxacin (Baytril)   | <=0.25 | 0.25-2 | S |
| Gentamicin               | <=2    | 2-8    | S |
| Marbofloxacin (Zeniquin) | <=0.25 | 0.25-2 | S |
| Potentiated Sulfonamide  | <=1    | 1-2    | I |

| Session No.    | Doctor  | Owner | Pet Name | Reference Range | Units |
|----------------|---------|-------|----------|-----------------|-------|
| EEA04696165    | BUDZYN  | COOK  | MAGGIE   |                 |       |
| Test Requested | Results |       |          |                 |       |

Suggested Dosing Guidelines based on MIC Results:

Amoxicillin: 16.5 mg/kg PO BID  
 Ampicillin (Sodium): 22 mg/kg IV or SC BID  
 Cefadroxil: 22 mg/kg PO BID  
 Cefazolin: 15 mg/kg IV or SC BID  
 Cefoxitin: 15 mg/kg IV or SC BID  
 Cefpodoxime: 5 mg/kg PO SID  
 Ceftiofur: 2.2 mg/kg SC SID  
 Cephalexin: 22 mg/kg PO BID  
 Clavamox: 13.75 mg/kg PO BID  
 Difloxacin: 5 mg/kg PO SID  
 Enrofloxacin: 5 mg/kg PO or SC SID  
 Gentamicin: 6 mg/kg IV or SC SID  
 Marbofloxacin: 2.75 mg/kg PO SID  
 TMS: 30 mg/kg PO SID

| MIC ORGANISM #2          | MIC(UG/ML) | TEST RANGE | INTERPRETATION |
|--------------------------|------------|------------|----------------|
| Organism #2              |            |            |                |
| Enterococcus species     |            |            |                |
| Amikacin                 | >=64       | 8-32       | R              |
| Amoxicillin              | 1          | 0.25-4     | S              |
| Ampicillin               | 1          | 0.25-4     | S              |
| Azithromycin             | 2          | 1-8        | R              |
| Cefadroxil               | N/A        | 1-16       | R              |
| Cefazolin                | N/A        | 1-16       | R              |
| Cefpodoxime (Simplicef)  | N/A        | 2-8        | R              |
| Cephalexin               | N/A        | 1-16       | R              |
| Clarithromycin           | 2          | 1-8        | R              |
| Clavamox                 | <=1        | 1-4        | S              |
| Clindamycin              | >=4        | 0.5-2      | R              |
| Difloxacin (Dicural)     | >=4        | 0.25-2     | R              |
| Doxycycline              | <=2        | 2-8        | S              |
| Enrofloxacin (Baytril)   | 2          | 0.25-2     | I              |
| Erythromycin             | 2          | 1-8        | R              |
| Marbofloxacin (Zeniquin) | 2          | 0.25-2     | I              |
| Potentiated Sulfonamide  | N/A        | 1-2        | R              |
| Tetracycline             | <=2        |            | S              |

Suggested Dosing Guidelines based on MIC Results:

Amoxicillin: 11 mg/kg PO BID  
 Ampicillin (Sodium): 22 mg/kg IV or SC BID  
 Azithromycin: 5 mg/kg PO BID day 1 then q 3 days  
 Clarithromycin: 7.5 mg/kg PO BID  
 Clavamox: 13.75 mg/kg PO BID  
 Doxycycline: 5 mg/kg PO SID  
 Enrofloxacin: Not recommended for this isolate  
 Erythromycin: 10 mg/kg PO TID  
 Marbofloxacin: 5.5 mg/kg PO SID  
 Tetracycline: 30 mg/kg PO SID

**Lake Forest Animal Hospital**

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Forest, VA 24551  
Tel: 434-385-6468  
Fax: 434-385-6469

|                   |                              |                    |                                 |
|-------------------|------------------------------|--------------------|---------------------------------|
| Doctor<br>TAUNTON | Owner<br>COOK                | Pet Name<br>MAGGIE | Received<br>07/22/2008          |
| Species<br>Feline | Breed<br>Domestic Short Hair | Sex<br>SF          | Pet Age<br>6Y                   |
|                   |                              |                    | Reported<br>07/22/2008 12:15 PM |

| Test Requested              | Results  | Reference Range | Units |
|-----------------------------|----------|-----------------|-------|
| <b>FELV ANTIGEN (ELISA)</b> |          |                 |       |
| FeLV Antigen (ELISA)        | Neg      | *Neg            |       |
| <b>FCV (IFA)</b>            |          |                 |       |
| 1:400                       | Positive |                 |       |
| 1:1600                      | Negative |                 |       |

A positive FCV titer indicates exposure to a coronavirus. It does not differentiate between FIP, feline enteric coronavirus exposure, or vaccination. Diagnosis of FIP should be based on history, physical examination, and other laboratory findings, including electrophoresis on effusions. FIP PCR testing on effusions, and/or FIP 7b ELISA testing on serum may be helpful in confirming FIP infection.

**FIV ANTIBODY**

|              |     |      |
|--------------|-----|------|
| FIV Antibody | Neg | *Neg |
|--------------|-----|------|

- - - - - FIV Interpretive Comment - - - - -

Positive result indicates that antibody to Feline Immunodeficiency virus (FIV) is present. In kittens under 6 months old this may be due to vaccination, passively acquired maternal antibodies, or infection with FIV; retesting is recommended after 6 months of age. Positive ELISA screening tests in cats over 6 months old may be due to infection with, or vaccination for, FIV. In non-vaccinated cats, a Western Blot test is required to confirm infection.

Negative result may indicate: 1) no FIV infection, or 2) FIV infection but inadequate time for seroconversion. Cats with potential exposure that test negative should be retested at least 3 to 4 months later. Kittens tested prior to 6 months old should be retested after 6 months whether their first test was positive or negative.

Equivocal result indicates a weak reaction (greater than the negative control, but less than the positive cutoff recommended by the manufacturer). If the cat is not vaccinated, FIV Western blot analysis is recommended.

- - - - -

07/2008 08:11:23 AM 07/19/08

**ANTECH DIAGNOSTICS** 2433 Globe Cove Rd Southaven MS 38671 Phone: 888-397-8378

**Lake Forest Animal Hospital**  
18510 Forest Rd  
Forest, VA 24551  
Tel: 434-385-6468  
Fax: 434-385-6469

|                   |                              |               |                    |                                 |
|-------------------|------------------------------|---------------|--------------------|---------------------------------|
|                   | Doctor<br>BUDZYN             | Owner<br>COOK | Pet Name<br>MAGGIE | Received<br>07/15/2008          |
| Species<br>Feline | Breed<br>Domestic Short Hair | Sex<br>SF     | Pet Age<br>6Y      | Reported<br>07/19/2008 11:33 AM |

| Test Requested                                                                                                                                            | Results      |           | Reference Range | Units     |           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------|-----------------|-----------|-----------|
| <b>CULTURE &amp; SENSITIVITIES</b>                                                                                                                        | <b>#1</b>    | <b>#2</b> | <b>#3</b>       | <b>#4</b> | <b>#5</b> |
| Source                                                                                                                                                    | Wound Armpit |           |                 |           |           |
| Preliminary #1                                                                                                                                            | 07/16/2008   |           |                 |           |           |
| No growth after 24 hours.                                                                                                                                 |              |           |                 |           |           |
| Preliminary #2                                                                                                                                            | 07/17/2008   |           |                 |           |           |
| No growth present after 48 hours.                                                                                                                         |              |           |                 |           |           |
| Preliminary #3                                                                                                                                            | 07/18/2008   |           |                 |           |           |
| No aerobic growth present after 72 hours. False negative results may occur if the patient is or has been on antibiotics within the last 7-10 days.        |              |           |                 |           |           |
| Preliminary #4                                                                                                                                            | 07/19/2008   |           |                 |           |           |
| No aerobic growth present after 96 hours. False negative results may occur if the patient is or has been on antibiotic therapy within the last 7-10 days. |              |           |                 |           |           |
| Final Report                                                                                                                                              | 07/19/2008   |           |                 |           |           |
| <b>CULTURE (ANAEROBIC)</b>                                                                                                                                |              |           |                 |           |           |
| Source                                                                                                                                                    | Wound Armpit |           |                 |           |           |
| Source                                                                                                                                                    |              |           |                 |           |           |
| Status                                                                                                                                                    | Final        |           |                 |           |           |
| Organism #1                                                                                                                                               |              |           |                 |           |           |
| No anaerobic bacteria isolated                                                                                                                            |              |           |                 |           |           |