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Sumner, Everett Luke [Box 1408]

REPATRIATION DEPARTMENT

Form D 876 (1965)

INSTITUTION R.G.H. DAW PARK.

SUMMARY OF CASE HISTORY

File No. R.19654 GB:JDB

NAME OF PATIENT	ADDRESS OF PATIENT	AGE
SUMNER, Everett Luke	MENINGIE. S.A.	70

NAME AND ADDRESS OF LOCAL MEDICAL OFFICER	DATE OF ADMISSION	DATE OF DISCHARGE XXXXXX Death
Dr. P.C. Gooden, TAILEM BEND. S.A.	25.11.66	10.12.66
	REFERRED BY: Dr. Gooden	
	DIAGNOSIS ON ADMISSION: Acute thrombosis left femoral artery.	
	R.M.O.: Dr. G. Burfield	SPECIALIST: Mr. M. Smith

FINAL DIAGNOSIS

Acute thrombosis left femoral artery.
Cause of death: cerebral thrombosis.

SUMMARY

HISTORY AND EXAMINATION ON ADMISSION

Admitted with a one week history of having a painful, swollen left foot. He gave a past history of having a right above-knee amputation one year ago because of ischaemic gangrene of his foot. He also gave a history of ischaemic heart disease and mild congestive cardiac failure. On examination left leg was cold, blue and swollen from the knee down. No pulses were palpable in this leg.

RECORD OF TREATMENT AND PROGRESS

An above-knee amputation was performed by Mr. Smith on 26.11.66.
Post-operatively he developed acute retention, requiring an indwelling catheter and also developed moderate congestive cardiac failure, requiring intensive diuretic therapy.
His general condition remained unchanged and as time passed it was obvious that a large area of the posterior flap in his tump was non-viable.
He also developed a large raw area between both buttocks.
On 9.12.66 he had a cerebro vascular accident invading the right side, and thereafter his condition rapidly deteriorated until he died on 10.12.66.

TESTS UNDERTAKEN AND RESULTS (where abnormal give particulars)

CONDITION ON DISCHARGE

RECOMMENDATIONS (Further treatment, medication, convalescence, limitations as to work, rehabilitation programme, etc.)

(T.P. DEARLOVE) Medical Superintendent — Rh — 14/12/1966

N 3/1

REPATRIATION DEPARTMENT - SOUTH AUSTRALIA

TL.130

BRANCH OFFICE MEMORANDUM

FILE No. M.19654

JMB:CMP

A14 RALAC 29/12

The Medical Officer-in-Charge,
O.P.C.,
KESWICK.

SUMNER, Everett Luke - 3626

The abovenamed died on 10th December, 1966.

K3 - Noted

X ray filing noted

30 DEC 1966

R. G. Collins

DEPUTY COMMISSIONER.

21 December, 1966.

NIF 21/12

REPATRIATION DEPARTMENT - SOUTH AUSTRALIA

BRANCH OFFICE MEMORANDUM

TL.39

FILE No. M.19654
JMB:CMP

The Clerk-in-Charge,
Registry Section,
R.G.H.,
SPRINGBANK.

SUMNER, Everett Luke - 3626

The abovenamed died on 10th December, 1966.

2. Please return Hospital file.

R. G. Collins
DEPUTY COMMISSIONER.

21 December, 1966.

Copy

REPATRIATION DEPARTMENT

PATHOLOGY REQUEST AND REPORT

File No. M19654

Surname and Initials	Age	Sex	Name and Address of L.M.O. (OPs. only)	Bed / Chair / Walk	Reg'n.	Return to
SUMNER E.L.	70	M.	Tel. No.		3626	18 Dail

TO: Microbiology, Biochemistry, Haematology, Histology (crossed out)

Clinical Notes and Investigation Required:—

Swab from sacrum
C/S please

Hll. for Dr Burfield
Medical Officer 8/12/1966

T.49/8.66—C.6859

REPORT:— SWAB bedsore

9.12.66

SMEAR: Polymorphs few Epithelial cells Yeast cells
Gram positive cocci ~~in clumps/chains~~ ✓ Gram negative bacilli ✓ Diphtheroids

CULTURE

Growth: Mixed —

Antibiotic Sensitivity (Sensitive, Doubtful or Resistant)

	Pen.	Tet.	Amp.	Ery.	Strep	Chlor.	Spira.	Linco.	Colist.	Neo.	
moderate Staph. (coagulase pos.)	R	R	R	R	R	S	S	S		D	
Strep. pyogenes											
Coliform											
heavy Proteus	R	R	S	R	S	S				S	
Pseudomonas											
heavy Strep. faecalis	R	R	S	R	R	S	R	R		R	
Candida albicans											

R Burfield
File please.

Signature [signature] 13/12/1966

Form 83 C (Path) (1966)

Swab, sacrum, C & S

10am.

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT

R No. H19654

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT

C. No.

INSTITUTION

*DEPARTMENT
*SPECIALIST ECG.

Surname SUMMER. Christian Name Everett Luke

Regt. No. 3626 Rank Unit Age 70

Receiving Treatment for Double amputation

Physician or Surgeon in Charge of Case Ward No. 8 A.O.

Object of Special *Treatment *Examination ECG please
(Where necessary state cardinal signs and symptoms)

B/P 100/70 P.G. fib.
Dyspn bed.

Medical Officer 9/12/66

* Strike one out

CLINICAL REPORT (Specialist or Department)

(Please write clearly)

14.12.66

Dr. G.E. Gibson reports:

Since the tracing taken the night previously, atrial fibrillation has persisted and the marked ST segment depression and biphasic T waves persist in the precordial leads.

Conclusion: The tracing continues to show evidence of continuing severe myocardial ischaemia, which is widespread.

Specialist

Skiagram No.

Form 83c
(Instruction 23)

Sams

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

INSTITUTION *DEPARTMENT *SPECIALIST

Surname Sumner **Christian Name** E.L.

Regt. No. 3626 **Rank** **Unit** **Age** 70

Receiving Treatment for

Physician or Surgeon in Charge of Case **Ward No.** 18. A.P.

Object of Special *Treatment *Examination E.C.G.

(Where necessary state cardinal signs and symptoms)

Medical Officer 8 / 12/66

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

14.12.66

Dr. G.E. Gibson reports:

Since the tracing taken on 26.11.66 atrial fibrillation has remained but slowed to an approximate rate of 90 - 100 per min. It remains grossly irregular and the appearances in V1 and RV4 still suggest a flutter with a 3:1 block. The most significant change, however, is increased ST segment depression in the precordial leads, which is marked and typical of severe generalized myocardial ischaemic disease.

Conclusion: The tracing continues to show coarse irregular atrial fibrillation with intermittent atrial flutter and evidence of severe ~~continuing~~ widespread myocardial disease.

BM[illegible]

Specialist

Skiagram No.

C.3534/65—PL

Form D23

Medical Certificate of the Cause of Death

Name: Everett [illegible] SUMNER

Aged: 70 years last birthday ; was attended by me.

Length of residence in Australia: Unknown

Died on the 10th day of December 1966.

CAUSE OF DEATH		Approximate interval between Onset and Death
I. Disease or condition directly leading to death*	(a) Cerebral thrombosis	2 days
	Due to (or as a consequence of)	
Antecedent Causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) Cerebral arteriosclerosis	Several years
	Due to (or as a consequence of)	
	(c) Generalised arteriosclerosis	

II.

Other Significant Conditions contributing to the death, but not related to the disease or condition causing it.

If deceased female, state (if known) whether or not deceased died within three months after giving birth to a child

Signed [illegible signature]

Legally Qualified Medical Practitioner

*This means the disease, injury, or complication which caused death—NOT the mode of dying, for example, heart failure, asphyxia, asthenia, etc.

500b25—4.65 4105

REPATRIATION GENERAL HOSPITAL—SPRINGBANK HL/106

MEMORANDUM

FILE NO. R.19654
KLC/JMP

The Deputy Commissioner,
Repatriation Department,
ADELAIDE. S.A.

The following death occurred at this Institution :- Ward 18.

SUMNER, Everett Luke. 3626.

Date of Death: 10th December, 1966.

Cause of Death: Cerebral thrombosis.
Cerebral arteriosclerosis.
Generalised arteriosclerosis.

Age: 70 years.

Religion: Congregational.

Next of Kin: Nephew, Mr. Howard Sumner, 13 Stacks Crescent, Elizabeth Downs - was not in attendance at the time of death, but was informed.

Funeral Arrangements: The Funeral took place at the West Terrace Cemetery on 14.12.66.

Funeral Directors: W.P. Cashel - Parkside.

T. P. Dearlove.
MEDICAL SUPERINTENDENT.

14.12.66

Mr H.L. SUMNER W.O 13 10·12·66.

1 PR GREY TROUSERS.
1 CHECK SHIRT.
1 GREY HAT.
1 SINGLET.
[illegible]
2 COMBS + 1 NAIL FILE.
$ 2.23
1 TIN OF BABY POWDER.
1 UNOPENED LETTER.
2 CIGARETTES
1 BOX OF USED MATCHES
1 COAT HANGER.

E A Pomeroy.
[illegible signature]

Received the above listed personal effects.
H Sumner (Nephew).

A/D. 11 am. 11/12/66

For Mr Carlsson,

Late Andrew ~~Sum~~ Sumner.

Ward 18.

Mr Howard Sumner Nephew of Elizabeth called at A/D. He had been notified by Elizabeth Police.

He requested me to phone Police at Meningie to advice another Nephew Mr Andrew Sumner of Meningie - who in turn would advise Mr Wilshire Sumner (Brother) at Point McLeay mission station. The Police officer agreed to assist -

Mr Howard Sumner of Elizabeth will call 9.30 am Monday 12th to see Mr Carlsson. He will need advice generally. and may not be able to act until He hears from Mr Wilshire Sumner Brother of deceased

LR

FORM D.877
(1965)

REPATRIATION DEPARTMENT

File No. R19654

NOTIFICATION OF DEATH OF A PATIENT IN A REPATRIATION HOSPITAL

Surname of Deceased	Christian Names	Age	Service No.
SUMNER	EVERETT LUKE	70	3626

Ward No.	Time of Death	Date of Death	Religion	Name of Ward Doctor
18	10 PM	10·12·66	CONG	DR BURFIELD

Name and address of Next of Kin	Relationship	Telephone No.
MR HOWARD SUMNER 13 STACKS CRES ELIZABETH DOWNS	NEPHEW	

Name and address of person nominated for notification purposes	Relationship	Telephone No.
MR HOWARD SUMNER 13 STACKS CRES ELIXABETH DOWNS	NEPHEW	ELIZABETH POLICE WTN

* THE NEXT OF KIN
* OR OTHER PERSON
TO BE NOTIFIED

* Was present at time of death
* Has been notified by me
* HAS NOT BEEN NOTIFIED

* Strike out where not applicable

OTHER NOTIFICATIONS:— C.I.C. Medical Records ☐ Enquiries ☐ Chaplain ☑ Matron ☐

Evening Super. ☑ Night Super. ☐ Admission Duty Officer ☑

S Walden 10/12/1966
Ward Sister

THE FOLLOWING SECTION IS TO BE COMPLETED ONLY BY THE OFFICER WHO ACTUALLY NOTIFIES THE NEXT OF KIN OR OTHER PERSON NOMINATED

Name of Person Notified	Method	Time	Date	Signature and Designation
MR HOWARD SUMNER	POLICE	10·40 PM	10·12·66	S Walden Sister

Authority and Record Card checked ☐

Death recorded in Death Register ☐

W.P. Bashel – Parkside.
Buried West Terrace Cemetery 14·12·66.

S Walden 10/12/1966
Signature and Designation

R.G.H. DAW PARK.

R.19654
GB:JDB

SUMNER, Everett Luke

MENINGIE. S.A.

70

XXXXXX Death

25.11.66

10.12.66

Dr. P.C. Gooden,
TAILEM BEND. S.A.

Dr. Gooden

Acute thrombosis left femoral artery.

Dr. G. Burfield   Mr. M. Smith

Acute thrombosis left femoral artery.
Cause of death: cerebral thrombosis.

Admitted with a one week history of having a painful, swollen left foot. He gave a past history of having a right above-knee amputation one year ago because of ischaemic gangrene of his foot. He also gave a history of ischaemic heart disease and mild congestive cardiac failure. On examination left leg was cold, blue and swollen from the knee down. No pulses were palpable in this leg.

An above-knee amputation was performed by Mr. Smith on 26.11.66.
Post-operatively he developed acute retention, requiring an indwelling catheter and also developed moderate congestive cardiac failure, requiring intensive diuretic therapy.
His general condition remained unchanged and as time passed it was obvious that a large area of the posterior flap in his tump was non-viable.
He also developed a large raw area between both buttocks.
On 9.12.66 he had a cerebro vascular accident invading the right side, and thereafter his condition rapidly deteriorated until he died on 10.12.66.

(T.P. DEARLOVE) [signature] 14 12 6

HL. 309

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

SUMMARY OF CASE HISTORY. File No.: R 19654

Name of Patient: E. L. SUMNER Age: 70

Diagnosis on admission: Acute thrombosis L femoral artery

Final diagnosis: " " " " "

Specialists: Mr. M. Smith. Cause of death - cerebral thrombosis.

Additional copies required for -
(1. Doctors other than L.M.O. always send a courtesy copy to other doctor involved.
(2. Interesting cases file.)

SUMMARY.
(Begin summary - "Thank you for your helpful note sent with patient" - if this applies.)

History and examination on admission.

Record of treatment and progress.

List all investigations (except those repeated several times).
1. Investigations giving normal results.
2. Investigations giving abnormal results.
(Remember L.M.O. may not know the names of tests, normal values or significance of abnormalities.)

Conclusion and comments.

Admitted with a 1/52 history of having a painful swollen L foot. He gave a past history of having a R above-knee amputation 17/12 ago because of ischaemic gangrene of his foot. He also gave a history of ischaemic heart disease and mild congestive cardiac failure. On examination ~~the whole of~~ his L leg was cold, blue and swollen from the knee down. No pulses were palpable in this leg.

An above-knee amputation was performed by Mr. Smith on 26/11/66.

Post operatively he developed acute retention, requiring an indwelling catheter, and also developed moderate congestive cardiac failure requiring intensive diuretic therapy.

His general condition remained unchanged and as time passed it was obvious that a large area of the posterior flap in his stump was non-viable.

P.T.O.

Disposal of patient and any follow up arranged, treatment on discharge and any particular advice given patient or relatives, e.g. prognosis or information about a malignant or incurable condition. Always make certain L.M.O. knows how much patient or relatives have been told.

Medical Officer.

If any comments on entitlements, pension rates or other purely departmental matters are necessary, these are placed at the end of the summary under the heading "Branch Office Note". The Typist does not include [illegible]

HL.309

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

SUMMARY OF CASE HISTORY. File No.:

Name of Patient E. L. SUMNER Age

Diagnosis on admission

Final diagnosis (cont)

Specialists

Additional copies required for -
(1. Doctors other than L.M.O. always send a courtesy copy to other doctor involved.
(2. Interesting cases file.)

SUMMARY.
(Begin summary - "Thank you for your helpful note sent with patient" - if this applies.)

History and examination on admission.

He also developed a large raw area between both buttocks.

Record of treatment and progress.

On 9/12/66 he had a C.V.A. involving the R side, and thereafter his condition rapidly deteriorated until he died on 10/12/66

List all investigations (except those repeated several times).
1. Investigations giving normal results.
2. Investigations giving abnormal results.
(Remember L.M.O. may not know the names of tests, normal values or significance of abnormalities.)

Conclusion and comments.

Disposal of patient and any follow up arranged, treatment on discharge and any particular advice given patient or relatives, e.g. prognosis or information about a malignant or incurable condition. Always make certain L.M.O. knows how much patient or relatives have been told.

[signature]
Medical Officer.
13/12/66

If any comments on entitlements, pension rates or other purely departmental matters are necessary, these are placed at the end of the summary under the heading "Branch Office Note". The Typist does not include these in L.M.O's ...

Next of Kin

nephew:
Cst Howard Summers

Mr Howard Sumners

13 Stacks Cres.

Elizabeth downs.

Elizabeth Police Station
WTM.

H.L. 96

TEMPERATURE CHART RECORDINGS

Ward 19 Date 19 / 11 /1966

Bed No.	Name	6 a.m.	10 a.m.	2 p.m.	6 p.m.	B/O	Weight	F
1	WILLIAMS		37^3 92 20	37 92 20	37^2-84-20	/		T.D.S.
2	ROWE		36^8 76 20	36^7 76 20	37^1-84-20	Ṫ		T.D.S.
3	STOW x	36^7 96 20	37^1 96 20	37 100 20	37-104-20	Ṫ		4
4	HARRIS		36^9 72 20		36^7-76-20	Ṫ		BD.
5	SOUTHAM.		36^7 76 18		36^5-92-20	Ṫ		B.D.
6	JANSEN x	36^8 84 20	37^2 80 22	37^5 88 20	37-84-20	Ṫ		4
7	ANDERSON x	36^5 64 20	36^7 80 18	36^9 80 20	37^3-92-20.	N.O	1DAY.	4
8	WILLIAMS x	36^8 80 20	36^2 76 20	36^5 68 20	36^2-80-20	Ṫ		4
9	MOORHOUSE		36^6 96 18	36^2. 92. 20	36^8-96-20	Ṫ		T.D.S
10	JERDEN		36^8 84 18	37. 80. 20	36^7-96-22	N.O	1.DAY	T.D.S.
11	LEWIS x	36 112 26	37^4 100 28	37^2 112 40	37^2 108-28	Ṫ		4
12	GOGLER x	36^5 72 26	37^2 72 20	37^1 80 20	37^4-96-20	Ṫ		4
13	FERGUSSON x	37^1 100 20	37^6 92 20	37^7. 88 20	37^8-80-20			4
14	SIEBERT x	37^7 90 20	37^5 84 18	37^3. 80 20	37^2-88-20	/		4
19 ~~15~~	WARNER x	35^8 72 20	36^9 72 20	35^3. 72 20	37^3-80-20	N.O.	7DAY.	4

R.G.H.

Form D 875 (1965)

TREATMENT SHEET

File No. R 19654

Surname	Christian Names	Age	Ward	Bed No.
SUMNER	Everett E.L.	70	18	

Date Ordered	DRUG OR TREATMENT	M.O.'s Initials	Date Stopped	M.O.'s Initials
25/11/66	0.25mgs I.V. of Lanoxin. 100 mgs Pethidine p.r.n.			
	Renewed A O 6 [illegible]			
25/11/66	Omnopon mg 20, when necessary repeat in 4 to 6 hours if necessary	[illegible] A Rumbold		
	4% + 1/5 after blood is finished	AR		
	Oral feeding			
26/11/66	0.25mgs of Lanoxin. T.D.S. (record HR as well as pulse)			
27/11/66	cap tetracyclin 250mg 6hly. syrup chlorpromazine 50mg to settle	[illegible]		
28/11/66	Continuous catheter drainage. Syrup chlorpromazine 100mg 6.00p.m. nocte. Repeat 50mg [illegible] p.r.n. Oral Terramycin b.d.	[illegible]		
6/12/66	Magnesium [illegible] large dressing below buttocks. [illegible] b.d.	[illegible]		
7/12/66	[illegible] 50mg q.i.d.	[illegible]		

C.3531/65—PL

THIS FORM TO BE COMPLETED BY ADMISSION CLERK FOR EVERY ADMISSION. TL.127

Form 83C (Adapted)

C.O. S.8/3/55 of 1.3.65
B.O. G.56/1/5

REPATRIATION DEPARTMENT
(S.A. BRANCH)

H No. 19654

TREATMENT AND REPORT FORM

INSTITUTION: R.G.H., SPRINGBANK   DEPARTMENT: X-RAY

Surname: SUMNER   Christian Names: Everett L.

Regt. No. 3626   Rank ______   Unit ______   Age ______

Receiving Treatment for ______

Physician or Surgeon in Charge of Case ______   Ward No. 18

Examination: ROUTINE CHEST X-RAY (Where necessary state cardinal signs and symptoms)

NORMAL	ACTIVE/PROB. ACTIVE	INACTIVE	SUSPECT ACTIVE	OTHER CONDITIONS

(RADIOLOGIST TO TICK APPROPRIATE COLUMN PLEASE.)

______ / /
Medical Officer

CLINICAL REPORT:

______
Specialist

Skiagram No. ______

WARD MEDICAL OFFICER

Arrangements are to be made for this patient to undergo a routine chest X-ray and the attached Form 83C is to be forwarded to the X-ray department, who will send for the patient when required to attend.

The only exceptions are those patients who have

(a) Had a chest X-ray within the last 12 months;

(b) Have been admitted for a chest condition.

In these cases, the Form 83C is to be endorsed accordingly and placed on the Hospital File.

FOR INCLUSION IN
PATIENTS FILE

Form 83B

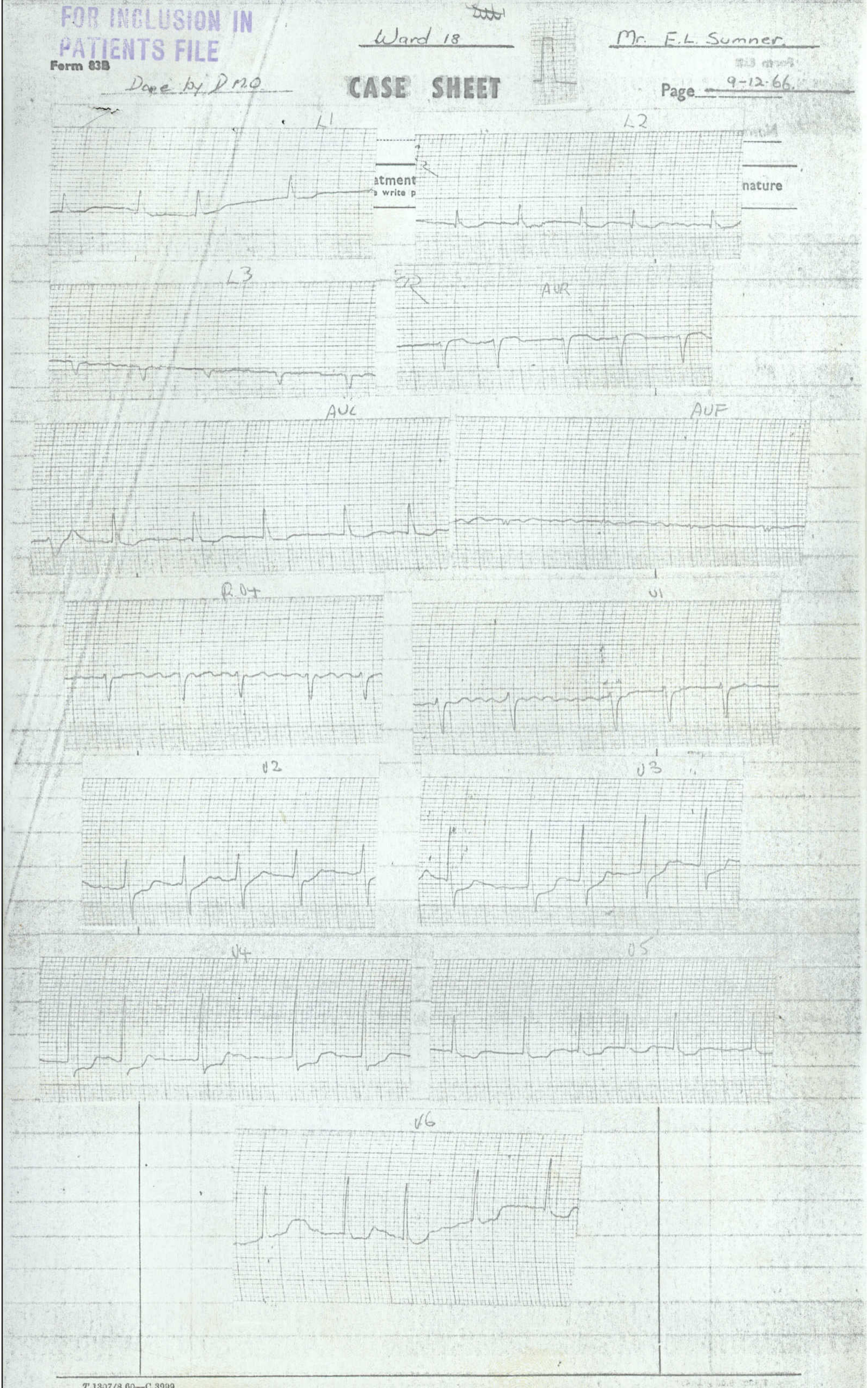
Done by D.M.O.

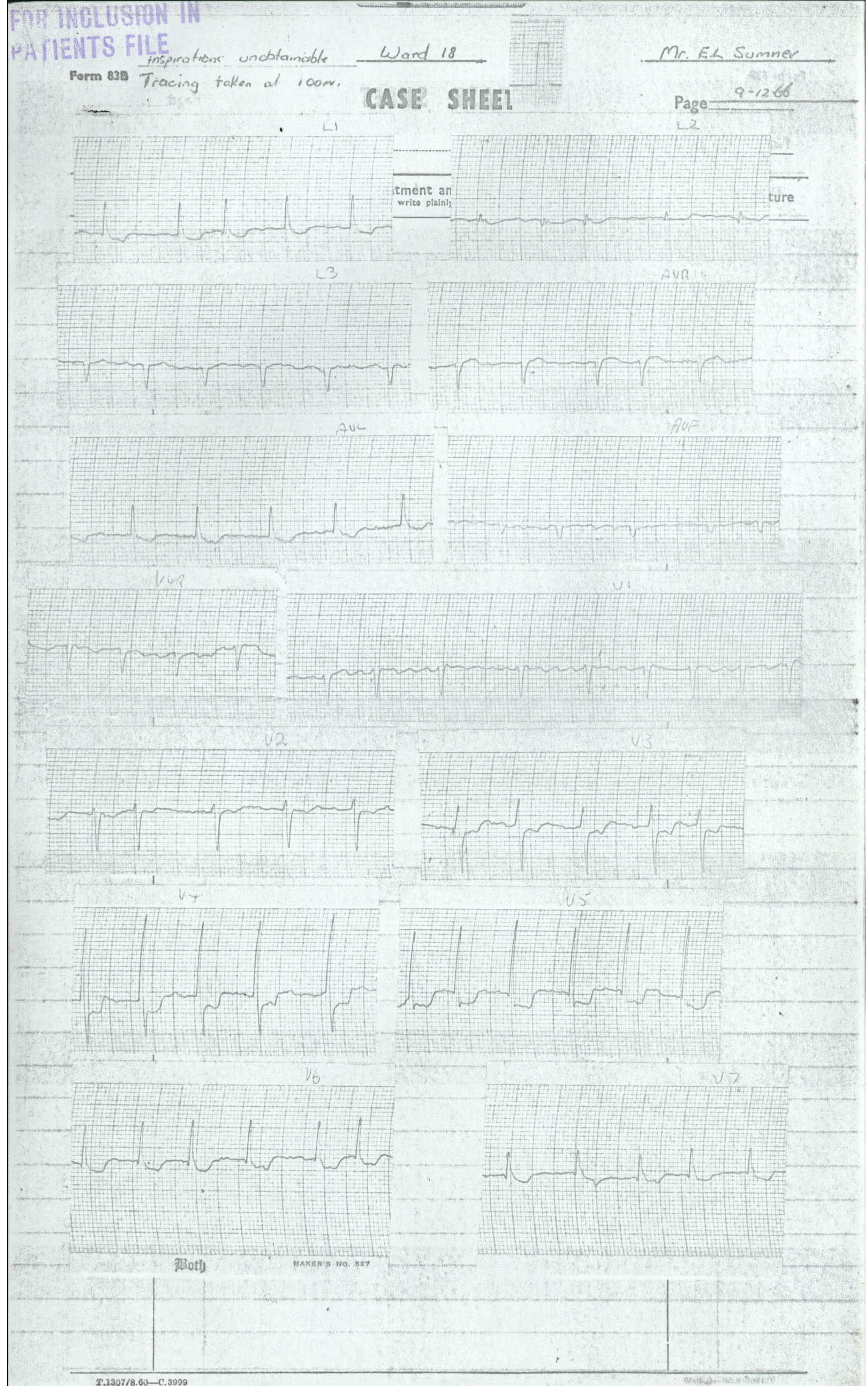
Ward 18

Mr. E.L. Sumner

CASE SHEET

Page 9-12-66.




FOR INCLUSION IN PATIENTS FILE
inspirations unobtainable
Tracing taken at 100m.
Form 83B
Ward 18
Mr. E.L. Sumner
CASE SHEET
Page 9-12-66
L1
L2
L3
AVR
AVL
AVF
V4R
V1
V2
V3
V4
V5
V6
V7
Both
MAKER'S NO. 527
T.1307/8.60—C.3999

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No. ....

R.G.H. SPRINGBANK

Date 10.12.66

Name SUMNER. Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2am									wet bed.	
6am									100+ wet bed.	
9am									wet bed +++.	
11am									Dry	
2pm										
4pm									Dry.	
									Wet Bed ++.	
6.30									dry.	

TOTALS				Saline Glucose Blood Serum			
TOTAL INTAKE					TOTAL OUTPUT		

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

A+D 207 254 215.

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No.

R.G.H. SPRINGBANK

Date 9-12-66

Name Mr Summers. Doctor Diagnosis

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
4am									+++	
9 30									15 +	WB. +
1pm										WB +
4pm									100.	
9									WB.	

TOTALS	—			Saline Glucose Blood Serum			115 +

TOTAL INTAKE —

TOTAL OUTPUT 115+.

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No.

R.G.H. SPRINGBANK

Date 8-12-66

Name Mr Summers Doctor Diagnosis

Time	FLUID INTAKE: By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT: Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
1am	orange	200								
3am									?50mls	(spilt by Pt)
5am	milk	200								
6am									300mls	
7am	Tea	150								
8am									200.	
9am	Cadial	150								
10am	Tea	150								
11am	Cadial	150							U.T.V	
12md	Milk	180								
1pm	Alcloids	150							160	
2.30	Tea	150								
3pm	Lemon	150								
4pm	"	130							Tried	
5pm	Tea	100							200	
6.30pm	Egg flipp	60								
8pm	Tea	100								
10pm	lemon	150.							UTV.	
12MN									Incontinent of urine +++	

TOTALS			Saline Glucose Blood Serum			
TOTAL INTAKE	2140.		TOTAL OUTPUT	960+++		

24 Hour Summary (by R.M.O.)

Loss by Vapourization

24 Hour Intake

24 Hour Output

24 Hour Balance

Progressive Balance

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No. ....

R.G.H. SPRINGBANK

Date 7·12·66

Name MR SUMNER Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
5am	Water	150							cath removed	
6a									250	
7am	Tea	100								
9am	egg flip	100								
10am	Tea	150								
11am	cordial	150								
12md	Tea	150								
1pm	H.C.F	150								
2p	Cordial	150							wet bed ++	
3p	Tea	150								
4pm	Cordial	150								
5pm	Tea	150								
6pm	Egg flip	150								
6.30	Cordial	90								
7pm	Milk	150							U.T.P.U.	
8pm	Tea	150							Small amt in bed.	
9pm	Cordial	90								
10pm	Cordial	90							"	
								12MN	wet bed ++ ? 400 cc's	

TOTALS			Saline Glucose Blood Serum			
TOTAL INTAKE 2270.				TOTAL OUTPUT 250 ++.		

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No. ....

R.G.H. SPRINGBANK

Date 6/12/66.

Name Summer. Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2	water	100								
6	water	150							400	
7Am	Tea	100								
8Am	egg flip	150								
9Am	cordial	100							200.	
10Am	Tea	100								
11Am	cordial	100.								
12md	Tea	150								
1pm	H.C.F	150								
2pm	~~[illegible]~~ Tea	150								
3pm	Cordial	100								
4pm	Egg Flip	150.							350.	
5pm	Tea	150.								
6pm	H.C.F.	150.								
7pm	Cordial.	100.								
8pm	Tea.	90.								
9pm	Cordial	150.								
10pm									350.	
12md									200	

TOTALS	2,140		Saline Glucose Blood Serum			1,500
TOTAL INTAKE 2.14				TOTAL OUTPUT 1.5		

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—11.65 8100

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No.

Name SUMNER. Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 10.12.66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
2am		70/?			96 irreg.			P. Areas. Turned
6am		60/?		39.7	104/40			P. Areas Turned
9Am								Fully sponged P/areas.
10Am		80/?		39.5.	100/50 IRREG.			M/Toilet
11:30								P/areas turned. M/Toilet – oral suction
1								M/Toilet
~~2pm~~ 2pm.		100/?		40	102/68 IRREG			P/areas. turned M/Toilet – oral suction ++. 2.05 Suction – nil
4pm								TURNED. P/AREAS.
6.30.					100/56.			Suction + Turned FHB
								Sponged Suctn + M/Toilet
9pm				35–	104/48.			Turned p/areas M/T Suction

Summary Fluids ml.

Urine ml.

Sleep hours

Rota

Sister

S.I.L.

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No.

Name: Mr Sumner. Dr. SISTER'S SPECIAL REPORT

Ward: 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date: 9-12-66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
2am	refused drink			36.6	84		—	Turned Pressure Areas
4am		110/70	Oxygen cat.	36	89		+++	Cheyne's Stokes Resp. Colour pale Pulse very
6am		100/65		35.4	92/18			irregular poor volume.
			Oxygen cat				4-30am	Dr Anthony examined pt.
8am.		100/70.			76/28			E.C.G. N.F.O'S
8.20 am					88/30 irreg			Pt. shaved P'A'S F.H.B. sponged Turned. Mouth throat aspirated
9.30								ECG taken
10		90/40		35.7	86 irreg/34.			P/Areas IRR to back
11.30					92.			Dressing to stump m/Toilet.
1pm								P/Areas turned Mouth aspirated
2pm		112/65.		38.5	90/32.			Respirating at head
4pm					88 irreg/32			P/areas. turned mouth toilet.
6pm		80/?.		39	92/irreg./32			P/areas turned. M/Toilet
8pm		90/? faint.			88 irreg.		W.B.	P/areas. turned M/toilet.
10		90/?.		39.4	84 irreg.			asleep.

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. ....

Name Mr Sumner. Dr. .... SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— .... Day—12 M.D.—12 M.N. .... Date 8-12-66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
2am				36.6	104/22	APEX 86		Turned. Pressure Areas
6am	~~Milk~~		O. DIGOXIN 0.25 mg given Furantoin 50mg	37	100/22	88	~~[illegible]~~	Sponge, Pressure areas.
7a	Light Diet							Dressing
9am								P/areas IRR. Sat out of bed.
10am				36.5	88/20			
11a								P/areas. Stump dressed. — v. slight ooze.
12pm			Furantoin 50mg.					
2pm			O/Digoxin 0.25mg	37.4	86/20			P/areas turned IRR.
4pm	Tea all sweet							P/Areas
5pm			Furadantin 50mg Chlorpromazine 100mg					P.Areas IRR
7pm				38	90/20			
8pm								P/Areas
9pm			Furadantin 50mgs.					P/Areas. PROFUSE SKIN ACTION.
10pm			O DIGOXIN 0.25mgs	37.9	68/26			P/areas turned LINEN CHANGED.
12mn								P. Areas Turned.

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No.

Name: MR SUMNER Dr.

SISTER'S SPECIAL REPORT

Ward: 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date: 7.12.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEX		
2am				37^{4}	68/20	80		P/Areas Turned catheter removed
6am			P/Digoxin 0.25mg	37^{7}	80/24	86		Sponged. 6am.
8AM	B/fast ✓							P/areas Turned IRR
10Am				38^{2}	84/24	86.		P/areas Turned on stomach
12MD	Lunch ✓		Furadantin 50mgs.					P/areas Turned IRR
2pm			Digoxin 0.25mg given	37^{5}	76/32	96.		wet bed P/areas Turned.
4pm	Dinner ✓							P/AREAS TURNED
6pm			FURADANTIN 50mg	37^{7}	72/24.	90.		P/AREAS TURNED
8pm			8.30 Syrup Largactil 50mg					P/AREAS TURNED.
10pm			FURADANTIN 50mg Digoxin 0.25	37	106/22	84.		P/AREAS TURNED.
12mn	sleeping							P'areas Turned

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota .... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name MR SUMMER Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 6/12/66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEY		
12mn			Syrup chlorp. 50mg tetracycline 25	37	88	92.		restless, awake
2				37	88	92		asleep
6			Tetracycline 250 Digoxin 0.25	36⁴	90	96		Fully sponged
8Am	B/fast —							IRR to back
10Am				37⁵	68/20	80.		Penile toilet mouth toilet eye toilet.
12md	Lunch —		TETRACYCLINE 250mg given					P/areas.
2pm			DIGOXIN 0.25mg given	37⁴	72/28	88		Summer P/areas. IRR
3pm						Mod. formed B.A.		
4pm						Mod. formed B.A.		Stump redressed. P/AREAS
5pm	Dinner ✓							
6pm			Syrup Chlorp. 100mg	37⁵	80/24.	84.		P/AREAS
8pm								IRR. P/AREAS.
10pm			Digoxin 0.25	37⁵	70/22	80		Sleeping.
12mn								Turned P/Areas

Summary Fluids ml.

Urine ml.

Sleep hours

Rota

Sister

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

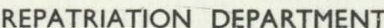
SPECIAL DRUGS:
Frusadantin 50mg
Q.I.D. — c̄ meals
and 9pm c̄ milk.

MR SUMNER BED NO: 15.

NAME OF PATIENT:

DATE	TIME	AMOUNT GIVEN	PROGRESSIVE TOTAL	SISTER'S SIGNATURE
7-12-66.	2pm.	100mgs.	100mgs	C. Isolito.
	5pm	50	150m	
	9pm.	50	200	
8-12-66	~~7~~ am.	50 ~~100~~mg	250mg	} [illegible]
	12md.	50 ~~100~~mg	300mg.	
	5pm.	50 mgms.	350 mgs.	} [illegible]
	9pm	50mgs.	400 mgms.	
9-12-66.	6am. }	not given		
	12md }			
	5pm	not given.		
	9pm.	"		
10-12-66		not given		

(15) 31.



FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. R19654

TEMPERATURE CHART

Commenced on 9 / 12 /1966

Name	SOMNER E. L.	Service No. 3626	Ward No. 18
Medication			
4 Hourly Date 12 Hourly	9	10	
Time			
Temperature (35.–41.5)			
Pulse (40–150)			
Respiration	18, 34, 32, 40	50, 68, 58	
Bowels	0	–	
Sputum			
Weight			
Fluids in / out	115+		
Blood Pressure			
Urine		1020 Acid Alb+ Pos Uro Cloudy.	
Memoranda			

56913/3/62–138,500–O/CH.

PLEASE USE BOTH SIDES

FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. ....

TEMPERATURE CHART

Commenced on / /19

Name		Service No.	Ward No.
Medication			
4 Hourly Date 12 Hourly			
Time			

Temperature

41.5
41.
40.5
40.
39.5
39.
38.5
38.
37.5
37.
36.5
36.
35.5
35.

Pulse

150
140
130
120
110
100
90
80
70
60
50
40

Respiration

Bowels

Sputum

Weight

Fluids in

Fluids out

Blood Pressure

Urine

Memoranda

PLEASE USE BOTH SIDES

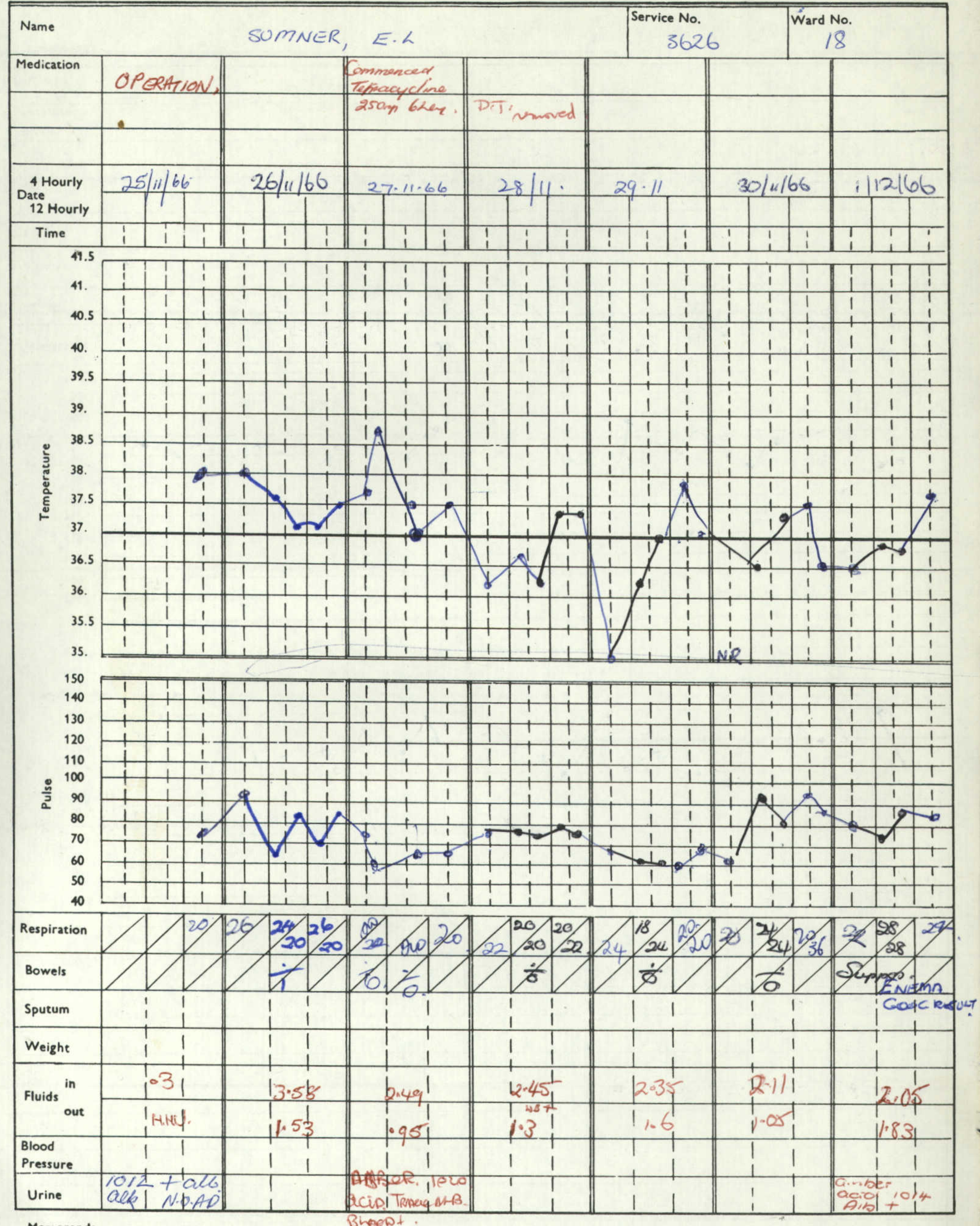
FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. R19654

TEMPERATURE CHART

Commenced on 25/11/1966



PLEASE USE BOTH SIDES

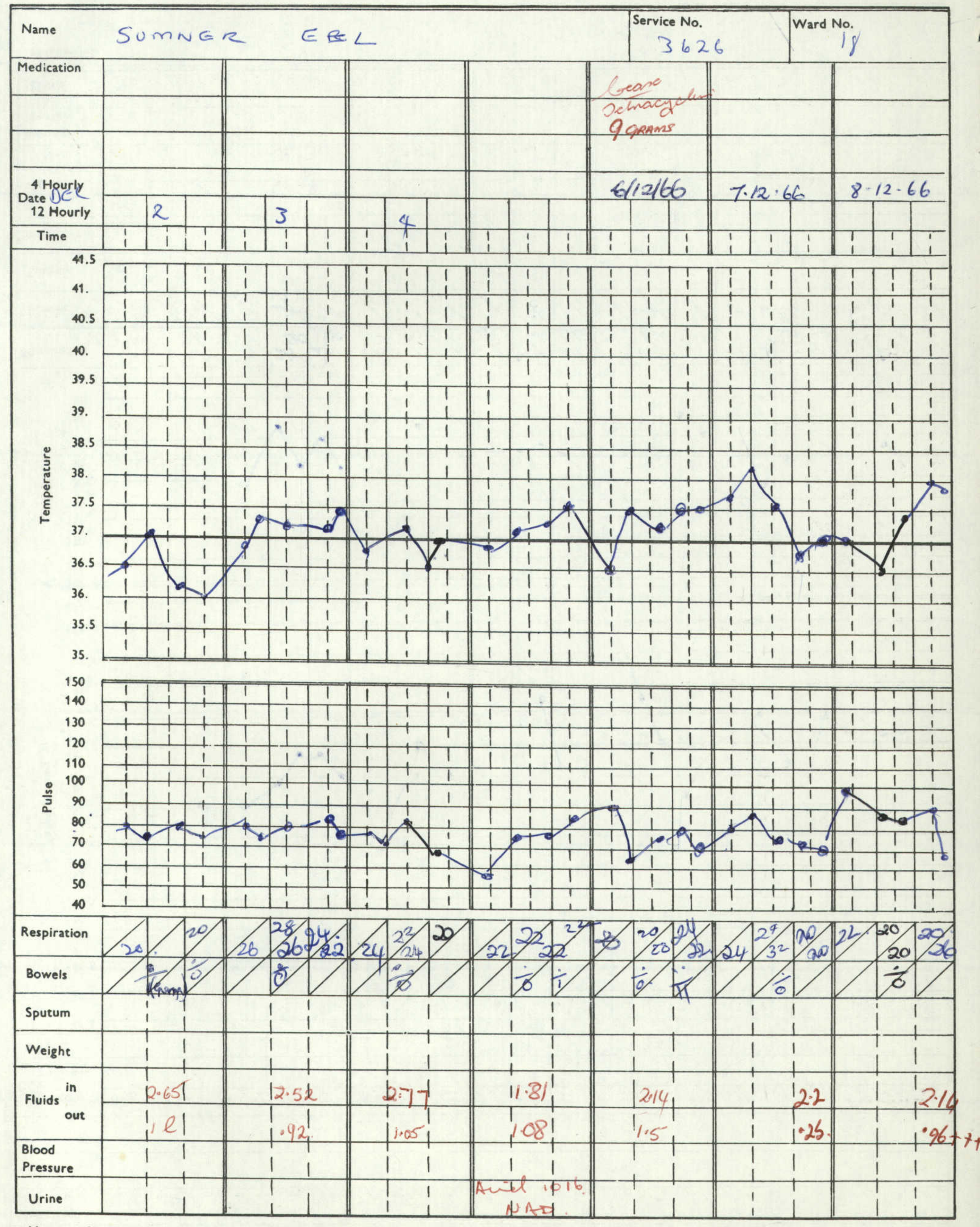
FORM 182
(1960)

REPATRIATION DEPARTMENT

TEMPERATURE CHART

File No. R 19654

Commenced on 2/12/1966



Memoranda

56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES

FORM D842 (1962)

REPATRIATION DEPARTMENT

WARD NURSING REPORT

FILE No. R 19654

MEDICAL OFFICER	WARD No.	BED No.
DR. JESSOP	18	31
NAME OF PATIENT	SERVICE No.	DATE OF ADMISSION
SUMNER, Everett L.	3626	25.11.66
ADDRESS OF PATIENT	AGE	RELIGION
Meningie . S.A.	70	CONG.

C.D.O. 3171

NAME AND ADDRESS OF NEXT OF KIN	TELEPHONE No.
NEPHEW. Mr. Howard Sumner. as above	c/o MENINGIE POLICE

DIAGNOSIS: Peripheral Vasc. Disease. (L) A.K AMPUTATION 25/11/66. 25/11. Amputation L. leg.

TEMP (O'A)	PULSE (O'A)	RESPIRATION (O'A)
38	86	22.
URINALYSIS (O'A)		WEIGHT

ITEM	ISSUED	RETURNED
LOCKER KEY		
PYJAMAS		
TOWELS		
D. GOWN		

DATE	ORDERS, MEDICATION, NURSING CARE AND ANY ABNORMAL SIGNS AND SYMPTOMS ARE TO BE RECORDED. IRRELEVANT AND INSIGNIFICANT INFORMATION IS NOT TO BE ENTERED	
25/11/66	Stretcher admission 4 Pm.	HB 16.5
	L leg very cyanosed	
	Pt [illegible] [illegible] T38 86/22.	
	For Amputation this Pm [illegible]	
	Blood Grouped + matched IV therapy commenced.	
	ECG CBP done	
	Patient fibrillating IV Digoxin 0.25 mgs	IM Pethidine 100 mgs PRN.
	given 5.15 Pm	
	IM Pethidine 100 mgms given 5.20 Pm.	Cot sides on bed
	Pre med :- atropine 0.6 mgms when called for.	Very restless
	Relatives have been notified by Meningie Police. Temp 38 @ 6pm	
	Pre-med atropin 0.6 mg + Phenergan 50mg @ 7.30 pm.	
	Returned to ward @ 9.50 pm. Op. amp. L. leg.	
	B.P. 140/80. P/66 irreg. Temp 37^6. Unconscious	
	but has since roused. S/B Dr Reynold	
	at 10.15 pm. IVT. 4% Dextrose in	(L) A.K Amputation
	1/5 N/saline to follow Blood.	
	IM Omnopon 20 mgs 6/24 PRN.	
	H/R. Satisfactory night. Very restless	
	at 1 am. IM Omnopon 20mg given	
	at 1.15 am c good effect.	
	Moderate amt of oozing from wound	
	- same reinforced. Very restless	
	again at 5 am, when sponged.	
	Observations satisfactory. BP 160/100	
	P. 90 - 100. T^6 38. Patient very	
	sweaty at 5.30 am. IV therapy	
	due through 10 am. [illegible]	
26/11/66.	Satisfactory day. Wound reinforced mod. amount	
	of oozing. Observations (4hly) satisfactory. Patient	
	on Digoxin 0.125 mg T.D.S. (6.2.10). Take pulse	
	beforehand as inclined to slow before 60. Take	
	apex beat 4hly. Patient having profuse skin	
	reactions all morning. Temp 38 + 37^2. I.M. Omnopon	
	20mg @ 8.30 A.M. + 3.10 pm. I.V. discontinued @	
	12 M.D. Taking fluids well + eating well. DMO.	

NAME OF PATIENT. Mr. Summer.

27.11.66. To see wound tomorrow (27.11.66) and ? remove drain.

E/R. Good night. Continuing to talk & sing to himself. Pulse still irregular. Apex beat 4 hourly. Having profuse skin actions frequently. Stump reinforced at 4pm. O' digoxin given at 10pm. Taking fluids well. IM Omnopon 20mgs 9pm.

N/R. Singing to himself early in the night. Pulse still irregular. Profuse skin actions. Stump dressing slightly. IM Omnopon 20mg at 3am. P/Areas & C+B attended. Obs 6am $\frac{120}{80}$ T 37[8] : 76 : 22. O' Digoxin 0.25mg given at 6am.

28.11.66. Satisfactory. Dressing taken down this A.M. S/B Dr. Marshall — Drains NOT removed as there was a large amt of haemo ooze. Pt. very restless and talkative @ 12md. IMI Omnopon 20mg given c̄ good effect. Pulse remains irregular. Temp elevated @ 10am 38[7] c 2pm. 37. Deep breathing enc. Nil expectorated. Fluids & diet taken very well. 3pm S/B Dr. Nilsen — to contd c̄ Digoxin T.D.S.

E/R. Very restless, trying to get out of bed 3pm. Took dressings off stump — bright blood ooze on same. S/B Dr Baxter. Settled & slept for couple of hours. IM Omnopon 20mg given 6pm. Syrup Chlorpromazine 50mgs 4.30 pm & 9pm. O/Tetracycline course commenced 6pm. Taking fluids & diet very eagerly. Frequent skin actions T 37[5].

Syr Chlorpromazine 50mg 4 hly prn
Tetracycline 250mgs 6hly

N/R Restless night chatting & singing. IM Omnopon 20mg given at 2.5a, Syrup Chlorpromazine 50mg given at 2.30am. Remained awake all until 3[30]a. talking. Skin actions persisting. O/Digoxin 0.25mg 6am. Difficult with C+B exercises, nil expectorated. HNPU since 9pm. Wound dressing ✓. Pulse irregular Obs 6am BP $\frac{100}{48}$ T 36[2] 78 : 20

28.11.66. Still confused this A.M. Eating and drinking well. Amputation dressing re-done and drains removed. Patient has not voided since 9pm last night though tried many times. Coughing and breathing exercises done ~~[illegible]~~ and cough productive. 4 hly chart varies. Omnopon 20mg @ 11:10AM. Patient catheterized @ 2pm. for 500 c.c. catheter to remain in situ. Eye ?, BP, as has conjunctivitis + Terramycin ointment

FORM D842 (CONTINUATION)
(1962)

NAME OF PATIENT. Mr. Sumner.

Date		Notes	Orders
28-11-66	E/R.	Very confused this evening unable to understand very much of what pt. was saying. Syrup Chlorpromazine 100mg given 6pm c̄ good effect.	Eye Toilets T.D.S. c̄ Ung Terramycin B.P. Penile Toilet. D.
		Obs 10pm T. 37⁴ 76/22. BP. 120/80.	
		Taking fluids well. Voiding + wet bed. +++. No ooze from wound.	
		B.N.O. Flatus ++. General Nursing Care.	
	N/R	Very restless night throwing off bed clothes + talking. Syrup Chlorpromazine 50mg at 12mn and 4am, with little effect. Im Omnopon 20mg at 6.25am. for pain in stump. Is a little more coherent this am. Voiding ✓	
		Obs ✓ 6a T35:68:24 BP 110/60 No ooze from wound. Digoxin 0.25mg given 6am.	
29.11.66		Comfortable day still confused & restless Syp. Chlorpromazine 50mg given 10am & 2pm. c̄ some effect. Obs- 2pm T.37 64/24 BP 105/80 Taking fluids & light diet well Voiding N/c ✓ No ooze from stump. General Nursing Care.	Syrup Chlorpromazine 50mg to be given strictly 4 Hly & 100mg @ 6pm. Fer. Check Hb. Today 16.5 Gm Light Minced Diet
	E.R.	Restless this evening, Syrup Chlorpromazine 100mg given @ 6pm. Pt. settled @ 7.30pm. Diet fluids ✓ Obs ✓ No oozing ✓ Voiding ✓	
	N/R	Fair night. Cheyne-stoking during night. Very restless at 3am Syrup chlorpromazine 50mg, and settled fairly well. Observations satisfactory although pulse slower.	
		No ooze from wound. Digoxin 0.25 @ 6am	
30.11.66		Fair day less confused than yesterday. Stump redressed, dark area of avascular necrosis on lower side. Taking diet & fluids well. Voiding	
		Obs 2pm BP 115/80 T. 37⁴ 80/24. B.N.O.	
	E/R.	Drowsy all evening Skin actions continue, skin cool + clammy. Breathing rapid at times with uneven depth. Syrup Chlorpromazine 100mg 6pm.	
	N/R	Syrup chlorpromazine 50mg at 11.15pm Slept very well. Breathing regular during night. Observations steady. Wound ✓ C.U.D. ✓. Digoxin 0.25mg 6am	

NAME OF PATIENT. Mr. Sumner.

1-12-66 Comfortable day. Only confused at times today has not needed. Syrup Chlorpromazine. Stump redressed
Obs 2pm 36^8 88/28 BP 105/60
Taking diet & fluids well. Feeding – Pt. to try & feed himself if possible. Suppository given 12mo.

Suppos.

E.R Restless at times Eye toilet and P/areas attended. Settled down at 10pm. Syrup chlorpromazine 50mgs given 6pm

N/R Awake at 11pm restless Syrup. Chlorpromazine 50mg given at 11pm has since slept well, catheter ✓
Observations BP 100/50 T 36^2 80:20

2-12-66 Good day. Tolerating fluids well and feeding himself at times. More rational but still confused at times. Not needed syrup chlorpromazine today.

Enema good result

E.R. Tolerating fluids, More rational this p.m. Eye toilets done. Pressure areas done – couple small cracks in skin, on back – Patient nursed on side. Syrup chlorpromazine 100mg given 6pm.

N/R Slept well. Profuse ~~perspirat~~ skin action at 3am
Voiding – fairly well. BP 6am 110/70 T 36^7 80:26

3-12-66 Satisfactory day, talking sensibly Dressing done this am & wound probed by Dr Sunfield. 55ml's old blood obtained. P/Areas attended. Taking diet & fluids fairly well. Output fair. Remains cold & sweaty. T2p 37^2 80/26

STUMP WOUND TO BE PROBED DAILY.

E/R Fairly restful this evening, remains vague & confused. Sy Chlorpromazine 100mgs 6pm. Eye toilet attended. P/areas treated – nursed on side. Taking fluids quite well. Catheter drainage only fair. Skin actions profuse at times bed linen changed 9pm as damp. 10pm obs. T 37^4 P76 R.22. A.P. 76. Antibiotics & Digoxin given.

N/R Slept quite well T $36^{2.9}$ P. 46:20 4am – pulse 72
Output poor. Profuse skin actions.
P/Areas attended. Digoxin 0.25mg given 6am

FORM D842 (CONTINUATION)
(1962)

NAME OF PATIENT. Mr Sumner.

4.12.66.	Comfortable day. Patient taking fluids and managing to feed himself quite well. Wound redressed and probed this A.M. - 90mls. old blood obtained. Pitting oedema of stump to a couple of inches from suture line. Blackened area seems larger today - has blister on this area. All treatment given and nursed on side. Temp 37² @ 10A.M. and 36⁵ @ 2p.m. Bowels not open 2 days. Ask Dr. re - tetracycline tomorrow. Urinary output poor compared to intake.	Ask re - tetracycline Monday.
E/R	Quiet evening until disturbed by new admission. Nursing care given Turn from side to side. Obs ✓ Voiding ✓ Taking diet & fluids ✓	
N/R	Slept well. P/Areas attended. Obs pulse 56 2a 6a 36⁹ : 58 : 22. Digoxin not given as pulse ↓ 60.	
5-12-66	Quiet day - stump probed only very sm amt haemoserous discharge. IRR to back pressure sore & pt turned 2 hrly. Taking diet & fluids well. B. NO. IDC ✓	
E.R	Glc. sup. c̄ good result of flu's B.A. I.D.C ✓. Slow c̄ fluids otherwise satis. No sedation given	
N/R	Slept quite well. 4 hrly obs satis/cerbory digoxin 0.25 mg 6am. Syrup Chlorpromazine 50mg @ 12 mn as patient became very restless.	
6-12-66	P/areas need constant attention IRR. T.P.S and nurse from side to side. turn 2/24 Encourage fluids I.D.C ✓.	Cease Tetracycline.
E.R	Usual evening. B.O. ii semi formed motion. Diet & fluids ✓. Becoming restless. @ 6.30pm Syrup Chlorpromazine 100mg given. Attention given to buttocks 2 hrly. Obs ✓ For Removal of urinary catheter tomorrow @ 6AM.	
N/R	Slept well. P/Areas & turns attended two hourly. Obs ✓. T. Urinary catheter removed 6am. T 6a 37 7.80/24. Digoxin 0.25mg	
7/12/66	As usual. Push fluids ✓. Catheter removed and has wet bed once. P/areas and turns 2/24. Dressing ✓ Commenced Furadantin 50mg Q.I.D.	
E.R.	Satisfactory. IRR. to buttocks. 8.30pm Syrup Chlorpromazine 50mg given. Has not passed urine this duty. very small amt on sheepskin.	
N/R.	Slept long periods. Urine passed as chart. Routine care.	

NAME OF PATIENT. Mr. Sumner.

8·12·66

Good day, buttocks still very sore. IAR given Unguita: N.A. dressing applied. Sat out in wheel chair for 1 hour this am but was very uncomfortable.
Not eating very well but taking fluids. Voiding, no wet beds. Dressing taken down - very slight ooze. To be seen by Dr Banfield tomorrow ? Sutures.

ER. Fair evening. Moderate amounts of fluids taken. Voiding ✓ Profuse skin action 10pm. Temp 6pm 38 T 10pm 37.9.

NR. Condition appeared satisfactory until 4am. When pt ~~became~~ started Cheyne's Stoke's Resp. Pulse weak irregular T 36. BP 110/70. Colour poor, cyanosed. Dr Anthony to see pt. E.C.G. taken. N.F.O's. Placed on S.I.L.
N/K notified (Message left at Meningie P.O to be forwarded to Meningie Police who will inform N/K.)
No further change. Pt irritable, will not take fluids. 6am Digoxin not given
Has had Oxygen cont'd.

9.12.66. Condition deteriorated - only semi conscious & not taking any fluid. Definite weakness of L. arm. ECG taken this am, Cheyne-stokes breathing at times, colour pale sweaty around head T° 38.5. pulse irregular in rate & volume. S/B Dr Banfield no further orders other than he'll see stump wound tomorrow. Aspiration of mucus from mouth & throat prn. Relative (nephew at Meningie) notified by telegram this am. about S.I.L. Voiding ✓ Bottle in situ.

ER. Pt condition deteriorating - semi conscious. Unable to swallow fluids. Voiding ✓ Cheynes stokes breathing at times. All listed nursing care ✓ T 39.4 10pm. BP 180/? P. irregular. A relative has visited.

[illegible signature]

FORM D842 (CONTINUATION)
(1962)

NAME OF PATIENT. SUMNER.

N/R.	Same night - Condition remains very poor. Cheyne Stokes Resps. Full nursing care given during night (P. areas, turns etc.) Has voided Temp 6am = 39^{7}
10·12·66	Condition remains very poor, pt moribund - (not active therapy to be given) 2hly nursing care given Oral suction when indicated. To have a urinal left in place if possible Salines to remain in situ at present. IRR. to pressure sore. Obs. 2pm. T.40 $\frac{102}{28}$ BP. 100/?. Condition deteriorated Resps very laboured & rapid T° 39^{8} P102 R58 Resps ceased 10 Pm

Sister in Charge WD 18.

Please place in x/m's "CR" file.

MR H. SUMNER

C/-.MENINGIE POLICE STATION

MENINGIE S.A.

YOUR UNCLE EVERETT SUMNER WAS PLACED ON THE SERIOUSLY ILL LIST AT 4.00 A.M. TODAY

MEDICAL SUPERINTENDENT REPAT HOSPITAL

W.J. CULLEN, HOSPITAL SECRETARY. R.G.H. DAW PK. 76-1241

M19654

KLC/PAV

Sent 10.25 a.m. 9.12.66

Form 83B

CASE SHEET

Page________

Name____________________ Ward No. 18.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
8/12/66	[illegible] adequately. Buttocks look a little drier.	[illegible signature]
9/12/66	4.15am: Called to see patient [illegible]. He was cold - clammy. + not responding.	
	B/p 110/70 P. 92 irregular Smooth -	
	Cheyne-stokes respirations.	
	Pupils R = L - both react Fundi - [illegible] seen	
	No neck stiffness. No facial weakness	
	HS - dual [illegible], lungs -	
	Fem. pulses present.	
	R) arm - flaccid unable to hold up	
	Reflexes - sluggish	
	L) arm - held above head in a athetoid-like fashion. Can move the arm.	
	Δ L) CVA -	
	Not known hard quickly this came on	
	? cereb. thrombosis	
	? cereb. embolus.	
Plan as S/L.	ECG - fibrillating marked ischaemic changes in chest leads ± digitalis effect. No def. evid. infarction	D Hutchins
10/12/66	Moribund. No active therapy indicated.	[illegible signature]
10-12-66.	10 pm. Called to see patient O/E Pupils fixed and dilated. No heart or breath sounds. Patient pronounced dead	[illegible signature]

T.1307/8.60—C.3999

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name: MR SUMNER Dr. **SISTER'S SPECIAL REPORT**

Ward: 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date: 5.12.66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEX		
2am				37^1	56:32	70		sleeping. P/Areas Turned.
6am			Tetracycline 250mg.	36^9	58:22	78.		Sponged. turned Digoxin not given
8am	Breakfast.							P/Areas turned
9am								Eye toilet M/Wash.
10				37^2	76/22	80.		
11am	Lunch.		Tetracycline 250mg					F.H-B sponged. IRR to back p/areas.
1.30.				37^3	82/20	96		Turned. Ung Terramycin to eyes.
2pm			Digoxin 0.25gr					
3pm								IRR lamp to back 10"
6pm			Tetracycline 250gr.	37^5	88/22.	96		sup c̄ good result. eye toilet
9pm			Digoxin 0.25gr		88.	90.		P/areas. settled

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota .... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name MR SUMNER Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 4.12.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEX		
2a				36^8	48/20	68		P/Areas.
4a				3[illegible]	72			
6a.			Tetracycline 250mg Digoxin 0.25mg	36^8	78/24	86.		Turned Sponged m/Toilet
10AM		118/96	Tetracycline 250mg @12MD Digoxin 0.25mg @2pm.	37^2.	72/22.	84.		turned, P/areas, eye toilet, [illegible], eye toilet p/area.
2pm				36^5	80/24	90.		F.W.O.B P/areas.
4pm.			Tetracycline 250mg					Turned.
6pm				37	68/20			
8a								
9a			Agarol Syr. Chlorpromazine 100mg.					P/areas a turned Restless.
10a			Digoxin 0.25mg					
2mn			Tetracycline 250mg					

Summary Fluids ml.

Urine ml.

Sleep hours

Rota

Sister

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.........

Name Mr. SUMNER. Dr. .... **SISTER'S SPECIAL REPORT**

Ward 18. Night—12 M.N.—12 M.D.—........ Day—12 M.D.—12 M.N. .... Date 3.12.66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	~~Bowels~~ APEX	Urine	Condition and Remarks
2a		110/60			80/20	88		asleep.
6a		110/70	Tetracycline 250mg Digoxin 0.25	36^7	80/26	92		M/Toilet Sponged set up.
7a	porridge poached Egg.							
9a								Face, hands, back sponged. DRESSING CHANGED WOUND PROBED 55mls old blood. Penile toilet
3 10a				37^3	72/28			M/Toilet Eye Toilet
11a.								P/Areas
2p			Tetracycline 250 DIGOXIN 0.25mg	37^2	80/26			P/Areas turned P/areas.
4pm.								
5pm.	Light diet.		Tetracycline 250mg.					
6pm.			Sy Largactil 100 mgms. Agarol.	37^2	84/24	96		P/areas.
7pm								~~Sleeping.~~ eye toilet
8pm.								P/areas M/toilet
10pm.			Digoxin 0.25 Tetracycline 250mg.	37^4	76/22	76		Sleeping awoken for treatment.

Summary Fluids........ml.

Urine........ml.

Sleep........hours

Rota .... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name MR SUMNER Dr. **SISTER'S SPECIAL REPORT**

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 2.12.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEX		
2am		110/60		P.A. 37[1]	84/20	92		asleep
6am		100/50	Digoxin 0.25 Tetracycline 250	36[5]	IRREG 80/20	88		Sponged awake C+R mouth toilet
10 AM		110/60		37	76/20	88		P/Areas toilet Penile toilet
12mp			Tetracycline 250mgs given					eye toilet. mouth toilet
1pm								P/areas.
2pm		110/60	Digoxin 0.25 mgs given	36[3]	80/20	80		eye toilet.
6pm		100/60.	Tetracycline 250mg Sy. Chloramphenicol 100mg @ 6pm.	36.	72/20.	90.		eye toilet + p. areas. P. areas.
10p.m		108/60	Digoxin 0.25mg.		80/20.	88.		

Summary Fluids ml.

Urine ml.

Sleep hours

Rota Sister

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name Sumner Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 1/12/66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						Apex		
2		130/90			86	94		awake. C/B.
3								asleep. P/areas
5								sponged.
6		138/80	Digoxin 0.25mg Tetracycline 250mg	36⁵	80	96		
8am								P/areas - turned Penile Toilet
10a.		120/60		36⁹	76/28			Eye Toilet P/areas.
12md.			Tetracycline 250mg					Stump Redressed. P/AREAS TURNED
2pm.		105/60	Digoxin 0.25mg	36⁸	88/28			P/areas & turned
2.30								ENEMA GIVEN.
3pm								
4pm								P/areas att, turned
5p				37⁶	84/24			Restless
6pm		100/60	Tetracycline 250mg Syrup chlor. 50mg					P/areas turned
9p		100/60			84			settled down.
10pm			Digoxin 0.25mg given					
11pm.			Sy. Tetracycline 250mg Chlorpromazine 50mg					restless,
12m								asleep.

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota .... Sister

REPATRIATION GENERAL HOSPITAL, SPRINGBANK R. or RX No.

Name Summen Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 30/11/66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						Resp		
2		120/60			84	90		asleep
3		108/50			86	82		Cheyne-stoking
4			Syrup chlorp. 50mg		72			[illegible]
5					68			restless
6		120/80	Digoxin 0.25mg.		64	70		sponged
7am	Light Diet		Agarol.					
8am								
10am		120/80		36⁵	92/24			P/areas
Noon			Tetracycline 250mg					P/care Slump Reduced
2pm.		125/80	Digoxin 0.25mg	37⁴	80/24			P/areas Restless Skin action
			Syr. Chlorpromazine 50mg.					Penile Toilet Eye Toilet
3.30								Sponge. Salup
5.30		132/90.		37⁵	94/20.	96.		Eye toilet Ung Terramycin
6pm			Tetracycline 250mg Syp Chlorpromazine 100mg.					P/Areas. skin action +
9pm								Sponge. Salup.
10pm		140/100.	Digoxin 0.25 Tetracycline 250	36⁵	88/36	100.		
11.15			Agarol. Syrup Chlorp 50mg.					

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota .... *Sister*

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. ....

Name MR. SUMNER Dr. .... SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— .... Day—12 M.D.—12 M.N. .... Date 29.11.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
						APEX		P/Areas. C+B. tried
2a		110/60		37	80/22	88		Very restless + talking incoherently
4a			Syr Chlorpromazine 50mg 4AM.					restless.
6Am		110/60	Digoxin 0.25mg Tetracycline 250mg Im Omnopon [illegible] at 6.25am	35	68/24	86		Sponged C+B. E/Toilet c/o pain in stump
7am	Semolina Boiled Egg							
9am								Pareas Sat up. Resile Toilet
10am		120/90	Syrup Chlorpromazine 50mg.	36^3	IRREG. 60/18	80		
11a			Tetracycline 250mg					Stump ✓
12md	Light Diet							Pareas, turned Eye Toilet c̄ [illegible]
2pm		105/80	Digoxin 0.25mg Syr. Chlorpromazine 50mg.	37	IRREG. 60/24.	76		Pareas.
4pm								p/Areas Turned
6pm	Light Diet	110/75	Syrup Chlorpromazine 100 Tetracycline 250mg.	37^2	80/24.	80		p/Areas Turned. Eye Toilet ✓
8pm								p/Areas Turned.
10pm		115/80	Digoxin 0.25mg Syrup Chlorpromazine 50mg	37	80/24.	74.		p/Areas Turned.
11pm								

Summary Fluids ....ml.

Urine ....ml.

Sleep ....hours

Rota .... Sister

H.L. 95

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. ....

Name Mr SUMNER Dr. .... SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— .... Day—12 M.D.—12 M.N. .... Date 28.11.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	~~Bowels~~ Apex	Urine	Condition and Remarks
2am		100/50	Im. Omnopon 20mg 2.5am. Syrup Chlorpromazine 50mg at 2.30am	37¹	72/22	88		Skin action. Restless, singing. P/Area. C+B.
6am		100/48	q/Tetracycline 250mg. Digoxin 0.25mg	36²	IRREG. 78	IRREG. 84/22		Skin action. Singing. Sponged. C+B.
10AM		120/60	Omnopon 20mg @ 11.40A.M. Tetracycline 250mg.		12	104/20		Pressure areas. Dressing done drain removed.
12 MD								
2pm		100/60			Irreg. 76	96/20		P/areas done.
4pm			Tetracycline 250mg					F.A.B. P/areas. Skin action
6pm		110/70	Syr Chlorpromazine 100mg	37⁴	IRREG. 80/20	88		P/areas. Skin action
8pm			Tetracycline 250mg.					
10pm		120/80	Digoxin 0.25mg	37⁴	IRREG. 76/22	80		P/areas sponged. Eye Toilet. Profuse skin action.
12mn			Syr Chlorpromazine 12MN 50mg.					Very noisy.

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... Sister

H.L. 95

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. ....

Name: SUMNER E. L. Dr. .... SISTER'S SPECIAL REPORT

Ward: 18 Night—12 M.N.—12 M.D.—.................. Day—12 M.D.—12 M.N. .... Date: 27.11.66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	~~Bowels~~ APEX	Urine	Condition and Remarks
2am.		130/70	I.M. Omnopon 20mg 3AM	37^5	IRREG 88/22.	88?		Profuse skin action P/Areas. C+B.
6am		120/80.	Digoxin 0.25mg	37^8	86/22	88.		Profuse skin action Sponged. C+B.
8am.	Breakfast. —							P/AREAS. C+B
9am						IRREG		STUMP REDRESSED. DRAINS NOT REMOVED
10am.		120/70.		38^7	60/16.	90.		P/AREAS.
12M.D.	Dinner —		I.M. Omnopon 20mg. 12MD					P/AREAS
2pm.		130/60.	Digoxin 0.25g	37	68/20	92.		P/AREAS
3.30								F.H.B. Sponged. Restless.
4.30			Syr Chlorpromazine 50mg.					Torn dressing off. Very
6pm		80/50. 125/80.	Omnopon 20mg	37^5	64/20.	88.		restless still
7.30.					76.			Sleeping Skin action ++
8.30								F.H.B. Sponged.
9pm			Syr Chlorpromazine 50mg.					Sleeping but
10pm		100/60.	Digoxin 0.25mg Tetracycline 250mg	37^2	72/16	88		awakes confused.

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... Sister

H.L. 95

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. ....

Name Sumner. E.L. Dr. .... SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— .... Day—12 M.D.—12 M.N. .... Date 26/11/66

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	~~Bowels~~ Apex Beat	Urine	Condition and Remarks
1am		160/100	Omnopon 20mgs 1.15am.		94.			awake, restless
2am		170/110			98.			
3am		140/90			88.			asleep
6am.		160/100		38	98/26			
7am.		158/60,						
8am		150/90.	Omnopon 20mg. 8'30 pm.		78. irreg	Apex		leg [illegible] - mod serous oozing.
12M.D.	Large lunch	138/88.	10am. Digoxin 0.25g	37^6	58 irreg	120.		Backdone.
2pm				37^2.	84.			
3'10pm			Omnopon 20mg,					
4pm		150/90	3.10pm. Digoxin 0.25mgs 4pm.		IRREG. 82	IRREG. 108		Sponged. C&B. P/areas. D. reinforced. Profuse skin action.
6pm		150/100		37^1	IRREG. 70	82		P/areas C&B. Profuse skin action.
9pm.			im Omnopon 20mgs.					P/areas. C&B. Profuse skin action
10pm		120/75	Digoxin 0.25mgs	37^5	IRREG. 72	irreg. 84		
12mn								P/Areas. C&B

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... Sister

H.L. 95

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No.

Name Mr. E L [illegible] Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 25.11.66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
RTW 10p		140/70		37^{6}	74 IRREG. /20			Unconscious
11pm		150/80			88			asleep.
12mn		158/80			90			

Summary Fluids ml.

Urine ml.

Sleep hours

Rota

Sister

H.L. 95

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

R. or RX No. R19654

Name SUMNER. E. L. Dr. SISTER'S SPECIAL REPORT

Ward 18 Night—12 M.N.—12 M.D.— Day—12 M.D.—12 M.N. Date 25.11.66.

Hour	Food and Drink	Blood Pressure	Medicine	Temp.	Pulse	Bowels	Urine	Condition and Remarks
5.15			0.5 mgms. IV Digoxin.					
5.30		165/110.			IRREG. 90			

Summary Fluids .... ml.

Urine .... ml.

Sleep .... hours

Rota

.... *Sister*

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R.G.H. SPRINGBANK

R or Rx No.

Date 5·12·66

Name Mr Sumner Doctor Diagnosis

Time	FLUID INTAKE: By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT: Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
									micro	✓
4a									100	
6a	water	150								
8	tea	150								
9	eggflip	150							200	
10	cordial	150								
12	tea	150								
1:30	cordial	150							180	
2:30	Tea	150								
3p	Cordial	150								
4p	Cordial	100							300	
5p	tea	150								
6p	H.C.F	150								
7p	Tea	150								
8p	Cordial	60							300	
9p										

TOTALS		1810	Saline Glucose Blood Serum				1080

TOTAL INTAKE 1810 TOTAL OUTPUT 1080

24 Hour Summary (by R.M.O.) ...

Loss by Vapourization ...

24 Hour Intake ...

24 Hour Output ...

24 Hour Balance ...

Progressive Balance ...

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No.

R.G.H. SPRINGBANK

Date 4·12·66.

Name MR SUMNER, Doctor Diagnosis

Time	FLUID INTAKE: By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT: Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2a	cordial	100								
4a									150	
5a	cordial	120								
6a	cordial	150.								
7AM	tea	150.								
8AM.	milk	150.								
9.30	tea	150.								
10.00	tea	150.							200	
11.00	H.C.F.C	150.								
12.00	tea	150.								
1.00	orange	150								
2.00	orange	150								
2.15	alkanite	150.								
2.45	tea	150.								
4p	orange	150							300	
5p	tea	150								
6p	orange	150								
6.30	egg flip	150								
8p	milk	150							230.	
9p	lemon	150								
12mn									150	

TOTALS	2,770		Saline Glucose Blood Serum			1,030

TOTAL INTAKE 2.77 TOTAL OUTPUT 1.03

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No.

R.G.H. SPRINGBANK

Date 3·12·66

Name Mr Sumner Doctor Diagnosis

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
4a	cordial	150							p/c 150	
5³⁰	cordial	150								
7am	Tea	150								
8am	Milk	150							P/C 200	
9A	Egg flip	150								
10am	Tea	150								
11am	Orange	150								
12MD	Tea	100							P/L 100	
1pm	Cordial	150								
2pm	Aktwite	150								
3pm	Tea	150								
30	Cordial	150								
4pm	Cordial	100							P/C. 120	
5	Tea	150								
6pm	Cordial	150								
7pm	Cordial	150								
8pm	Tea	120							250	
10pm	Cordial	100							P/C 400	
12mn										

TOTALS	2520		Saline Glucose Blood Serum			920

TOTAL INTAKE 2·52 TOTAL OUTPUT ·92

24 Hour Summary (by R.M.O.)

Loss by Vapourization

24 Hour Intake

24 Hour Output

24 Hour Balance

Progressive Balance

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No. ....

R.G.H. SPRINGBANK

Date 2.12.66

Name Mr SUMNER Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
12^{20}	water	100								
4am	water	150							200	
6am	water	250								
8am	Tea	150								
9am	water	100							300	
9am	egg flip	150								
10am	Tea	150								
11am	Cordial	150								
12md	Tea	150								
1pm	H.C.F	150								
2pm	orange	150.								
3pm	Tea	150								B.O. good
4pm	Orange	150							200	result[illegible]
5pm	Tea	150								
6pm	H.C.F.	150								
7pm	Orange	150.								
8pm	milk	150							100.	
9pm	orange	100.								
12mn									p/c 100	

TOTALS	2650		Saline Glucose Blood Serum			1,000
TOTAL INTAKE	2.65			TOTAL OUTPUT	1 l	

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R.G.H. SPRINGBANK

R or Rx No.

Date 1/12/66

Name MR SUMNER Doctor Diagnosis

Time	FLUID INTAKE By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2	water	100								
4	water	100							800	
6	water	150								
7a	Tea	150								
8a	Egg flip	150							P/c 200	
9a	Tea	150								
10am	Cordial	150								
11am	Milk.	150								
12a	Tea	150							P/c 200	
1p	Aktavite	150								
2	cordial	100								
3										
4pm	Cordial	150							180	
5p	Tea	100								
6p	egg flip	150								
8p	Tea	150							300	
12MD									P/c 150	

TOTALS	2050		Saline Glucose Blood Serum			1830

TOTAL INTAKE 2.05

TOTAL OUTPUT 1.83

24 Hour Summary (by R.M.O.)

Loss by Vapourization

24 Hour Intake

24 Hour Output

24 Hour Balance

Progressive Balance

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R.G.H. SPRINGBANK

R or Rx No. ....

Date 30/11/66

Name Summers Doctor .... Diagnosis ....

Time	FLUID INTAKE By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2	water	100							300	
5	water	150								
6									250	
7a	milk	150								
9a	milk	150							P/c 150	
10a	Egg flip	150								
11a	Lemon	150								
12md	milk	150								
1p	aktavite	150							P/c. 150	
2p	lemon	150								
4pm	lemon	150								
5	milk	150								
6	egg flip	120								
7	cordial	90							p/c 200	
8	cordial	120								
9	cordial	100								
11	cordial	100								

TOTALS	2110		Saline Glucose Blood Serum			1050

TOTAL INTAKE 2110 — TOTAL OUTPUT 1050

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

+ ~~300~~.

R or Rx No. ....

R.G.H. SPRINGBANK

Date 29·11·66

Name MR SUMNER .... Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
12^30	cordial	150								
4a	cordial	50							300	
6am	cordial	120								
7am	milk	150								
8am.	milk	120							P/c 250	
9am	Eggflip	150								
10a	water	150								
11a	water	150								
12md.	milk	120							P/c. 200	
1pm	water	100								
2pm	aktavite	150								
3a	milk	150								
4pm.	Water.	120							P/C. 300.	
5.	Milk	120								
6pm	Water.	150.								
7pm	Water.	120.								
8	Cordial.	120.								
9.	Cordial.	90.								
10.									P/C. 600.	

TOTALS	2350		Saline Glucose Blood Serum				

TOTAL INTAKE 2350

TOTAL OUTPUT 1600

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

FLUID BALANCE CHART (24 Hourly)

H.L. 100

R or Rx No. ....

R.G.H. SPRINGBANK

Date 28.11.66

Name MR SUMNER Doctor .... Diagnosis ....

Time	FLUID INTAKE: By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT: Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2am	cordial	150.								
4am	cordial	50								
6am	cordial	100								
7AM	tea	150.								
8AM	cordial	100.							U.T.U.	
9AM	cordial	100.								
10AM.	egg flip	150.							UTU	
11AM	egg flip	150.								
12MD.	egg flip.	150.							U.T.U.	
12.30	tea	150								
1.30	altavite	150							UTU.	
2.00									500	indwelling catheter.
4pm	cordial	150							100.	
4.30	cordial	150								
4.45	Milk	150.								
6pm	egg flip	150								
7pm	cordial	150.							P/C	
8pm	ablatrile	150							300 wet bed	
9pm	cordial	150								
10pm										
12mn									P/C 400	

TOTALS	2,450		Saline Glucose Blood Serum				1,300

TOTAL INTAKE 2.45 TOTAL OUTPUT 1.3 NBT

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R or Rx No.

R.G.H. SPRINGBANK

Date 27.11.66

Name Mr Sumner. Doctor Diagnosis

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
2a	cordial	150							i	
6a	water	150							250.	
7am	Tea	150								
8.	Cordial	150								
9.	Cordial	150								
10	Tea	150								
11.	Cordial	150							300	
12.	Tea	150								
1pm	Cordial.	150								
2pm	H.C.F.	150.								
2pm	Tea.	90								
3pm	Cordial	150								
4pm	water	150								
5	tea	150								
6	cordial	150.								
7	eggflip	150.								
9	cordial	150.							400	

TOTALS	2490		Saline Glucose Blood Serum			950

TOTAL INTAKE 2.49.

TOTAL OUTPUT .95

24 Hour Summary (by R.M.O.)

Loss by Vapourization

24 Hour Intake

24 Hour Output

24 Hour Balance

Progressive Balance

20M—8.66 3640

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R.G.H. SPRINGBANK

R or Rx No.

Date 26/11/66

Name Sumner E.L. Doctor Diagnosis

Time	FLUID INTAKE By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	FLUID OUTPUT Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
12mn	water	60	IV blood (200)	200						
1	water	60								
1.45			4% Dext in 1/5 N/S (1000).							
3	water	60							W.B	
6	water	100							200.	
7	water	60								
8pm	tea	90.								
9pm	egg flip	150.								
10pm	tea	150								
10.45	milk	90.								
10.30	Cordial	150.								
11.00	cordial	150							250.	
12.30	tea	150.	I.V. discontinued ~~? comp.~~	~~1000~~						
1.30	cordial	100.							200	
2.30	cordial	200.								
4pm	cordial	120								
5pm	tea	120								
6pm.	cordial	150							300	
7pm	cordial	150								
8.30	cordial	150							250	
9pm	cordial	150								
12mn	cordial	150							300	

TOTALS	2380	1200	Saline Glucose Blood Serum			1,530

TOTAL INTAKE 3,580 3.58

TOTAL OUTPUT 1.53

24 Hour Summary (by R.M.O.)

Loss by Vapourization

24 Hour Intake

24 Hour Output

24 Hour Balance

Progressive Balance

H.L. 100

FLUID BALANCE CHART (24 Hourly)

R.G.H. SPRINGBANK

R or Rx No. ....

Date 25/11/66

Name SUMNER E.L. Doctor .... Diagnosis ....

Time	FLUID INTAKE				FLUID OUTPUT					
	By Mouth Description	Amt. (mls.)	Intravenously Description	Amt. (mls.)	Vomitus Description	Amt. (mls.)	Stomach Tube Description	Amt. (mls.)	Urine (mls.)	Output by Rectum (mls.)
5am	FASTING.		10 4% Dext. 1/5 N/S Bag (1006)							
9.45			Blood Commenced	300						

TOTALS		300	Saline Glucose Blood Serum			

TOTAL INTAKE 300

TOTAL OUTPUT HNU

24 Hour Summary (by R.M.O.) ....

Loss by Vapourization ....

24 Hour Intake ....

24 Hour Output ....

24 Hour Balance ....

Progressive Balance ....

20M—8.66 3640

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

INSTITUTION RGH(P) *DEPARTMENT *SPECIALIST Blood Bank

Surname SUMNER Christian Name K. L.

Regt. No. 8686. Rank Unit Age 71

Receiving Treatment for Peripheral vascular disease

Physician or Surgeon in Charge of Case M Menner Ward No. 18

Object of Special *Treatment *Examination ECG please.

(Where necessary state cardinal signs and symptoms)

Rapid irregularly irregular pulse. gangrenous leg.

Medical Officer [signature] 5.12.66

*Strike one out

CLINICAL REPORT (Specialist or Department)

(Please write clearly)

6.12.66

Dr. G.E. Gibson reports:

The rhythm is variable and in greatest is coarse atrial fibrillation, but in RV4 and V1 is seen atrial flutter with a variable 3:1 or 2:1 block, thus givin an irregular ventricular rate. Occasional ectopic contractions are also seen. Q waves seen in L3 and aVF may represent old infarction. Elsewhere QRS is normal. ST segments are iso-electric and T waves are generally flattened. Left axis deviation, horizontal heart position and mild clockwise rotation.

Conclusion: The rhythm is grossly abnormal and ranges between coarse atrial fibrillation and atrial flutter with a variable 2:1, 3:1 block. T waves changes suggest generalized degenerative myocardial disease.

[signature]
Specialist

Skiagram No.

C.3534/65—PL

Form 70 A
(Instruction 78)

REPATRIATION DEPARTMENT

DUPLICATE

PRESCRIPTION FORM

No.

Institution

Name SUMNER . E.L. Ward 18

Reg. No. 3626. Rank Unit

PRESCRIPTION	REPEATS	
	Date	Initials of M.O
R/ Soframycin Eye drops		
	17473	

Medical Officer

29/11/1966.

Dispenser's Initials [illegible] / /19

T.788/4.62—C.2389

Form 83B

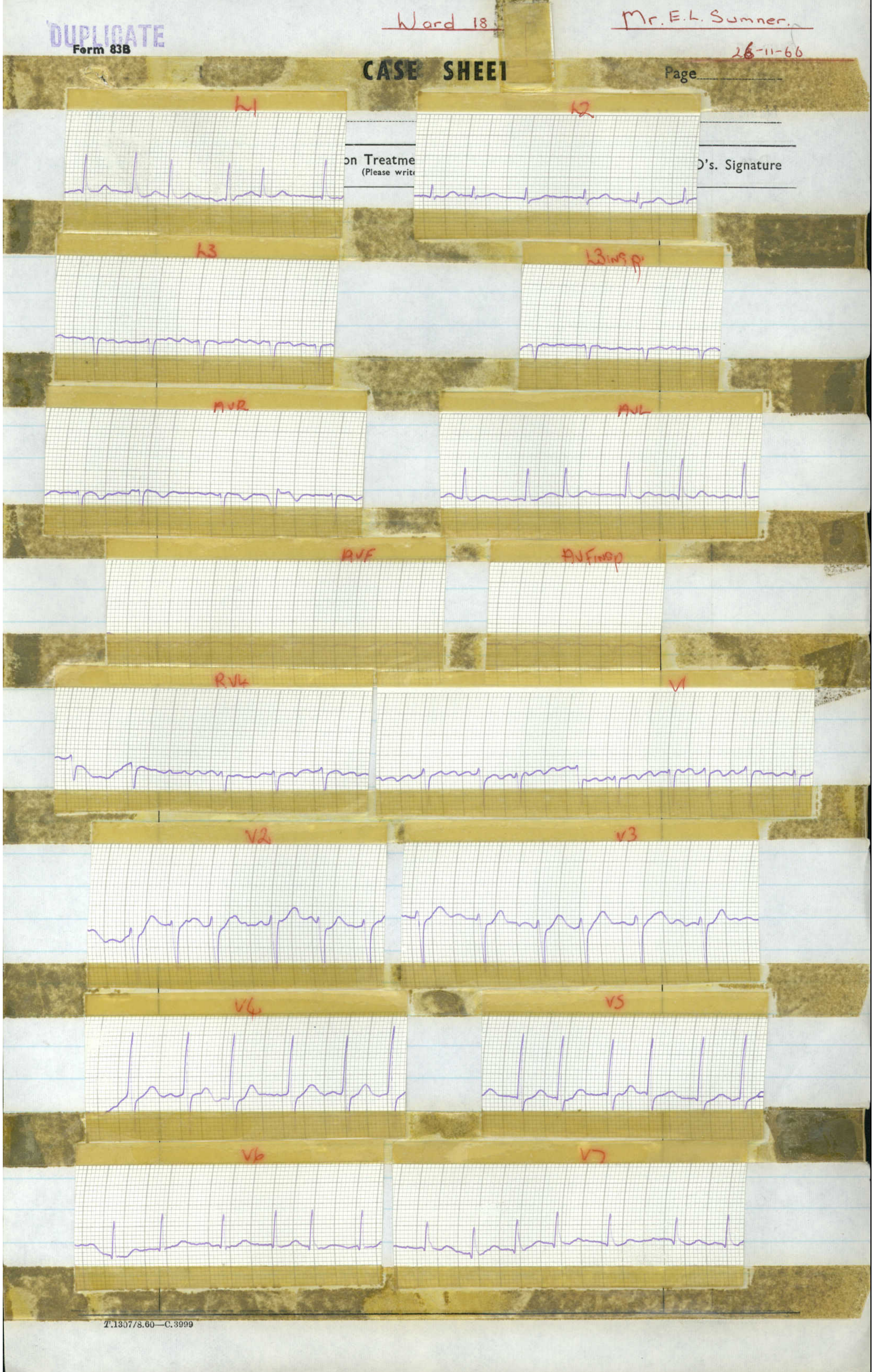
CASE SHEET

Page______

Name E. L. SUMMER　　Ward No.______

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
29/11/66	Still confused at night. No drainage from stump. Urine output satisfactory. Check Hb	[signature]
1/12/66.	Mentally much improved. Large area of lower skin flap is black & will probably slough	[signature]
3/12/66	Stump probed. Moderate amount of bloody discharge. Black area is extending along the suture line. For daily dressing.	[signature]
6/12/66.	Has large sore areas between both buttocks. Stump looks unchanged & large part of black area may be superficial. For removal of catheter.	[signature]
7/12/66	Further discharge from centre of stump. Has not voided yet but he is not uncomfortable & bladder not palpable.	[signature]
10.45 pm.	No urine passed since this morning but in wet bed this afternoon. Pt. asleep. & bladder not distended. Pt. comfortable. To leave catheter until tomorrow.	[signature]

T.1307/8.60—C.3999


DUPLICATE
Form 83B
Ward 18
Mr. E.L. Sumner.
26-11-60
CASE SHEET
Page
on Treatme
(Please writ
D's. Signature
L1
L2
L3
L3 insp
AVR
AVL
AVF
AVF insp
RV4
V1
V2
V3
V4
V5
V6
V7
T.1307/8.60—C.3999

REPATRIATION DEPARTMENT

Form D.878 (1966)

LABORATORY REPORT SHEET

Attach *IN/OUT-PATIENT reports only

* (Delete word not applicable)

Name	File No.

N.B.—Reports must be accurately and firmly fixed

14th Report

13th Report

12th Report

11th Report

10th Report

9th Report

8th Report

7th Report

6th Report

5th Report

REPATRIATION DEPARTMENT

PATHOLOGY REQUEST AND REPORT

Copy File No. 419654

Surname and Initials	Age	Sex	Name and Address of L.M.O. (OPs. only)	Bed	Reg'n.	Return to
SUMNER E.L.	70	M	Tel. No.	Bed	3626	18

TO: Microbiology ~~Biochemistry~~ ~~Haematology~~ ~~Histology~~

Clinical Notes and Investigation Required:—

Micro urine for C&S.

[signature] for Dr. Banfield
Medical Officer 5/12/1966

T.49/8.66—C.6859

REPORT:—URINE MICROSCOPY, CULTURE 5-12-66.

Casts: Hyaline .... Finely Granular .... Coarsely Granular .... Cellular .... Waxy .... Fatty ....

Cells: Leucocytes Very numerous per high power field
Erythrocytes .... per high power field
Epithelial .... per high power field
Bacilli Numerous. Crystals ....
Streptococci ....
Cocci .... Amorphous urate

Growth ✓

Antibiotic Sensitivity (Sensitive, Doubtful or Resistant)

	Tet.	Sul.	N.-f.-t.	Amp.	Nal. ac.	Strep.	Chlor.	Col.:t.	Kan.	
Coliform HEAVY	R	R	S	R	S	R	S			
Proteus										
Strep.										
Staph. (coagulase pos.)										
Psudomonas										

Form 83 C (Path) (1966) 32 — Signature [signature] 6/12/1966

Urine micro C&S

Form 83 C (Path) (1966) — Signature [signature] 6/12/1966

Swab, left stump, culture

Form 83 C (Path) (1966) HD — Signature [signature] 29/11/1966

Form 83 C (Path) (1966) HL — Signature / /19

REPATRIATION DEPARTMENT

Form D.878 (1966)

LABORATORY REPORT SHEET

Attach *IN/OUT-PATIENT reports only
* (Delete word not applicable)

Name	File No.

N.B.—Reports must be accurately and firmly fixed

14th Report

13th Report

12th Report

11th Report

10th Report

9th Report

8th Report

7th Report

6th Report

5th Report

4th Report

REPATRIATION DEPARTMENT

PATHOLOGY REQUEST AND REPORT File No. H19654

Copy

Initials	Age	Sex	Name and Address of L.M.O. (OPs. only)	Bed	Reg'n.	Return to
SUMNER EL	70	m	Tel. No.	Bed	3626	18

Clinical Notes and Investigation Required:—

Swab from L. Stump.

for Dr. Benfield
Medical Officer 5/12/1966

T.49/8.66—C.6859

5.12.66

SWAB

SMEAR: Polymorphs .... Epithelial cells .... Yeast cells ....
Gram positive cocci in clumps/chains .... Gram negative bacilli .... Diphtheroids ....

Some Detritis present

CULTURE

Growth: Not significant

	Antibiotic Sensitivity (Sensitive, Doubtful or Resistant)										
	Pen.	Tet.	Amp.	Ery.	Strep.	Chlor.	Spira.	Linco.	Colist.	Neo.	
Staph. (coagulase pos.)											
Strep. pyogenes											
Coliform											
Proteus											
Pseudomonas											
Strep. faecalis											
Candida albicans											

Form 83 C (Path) (1966)

Signature 6/12/1966

Swab, left stump, culture

Form 83 C (Path) (1966)

HD

Signature 29/11/1966

Form 83 C (Path) (1966)

Signature / /19

H6

REPATRIATION DEPARTMENT

Form D.878
(1966)

LABORATORY REPORT SHEET

Attach *IN/OUT-PATIENT reports only
* (Delete word not applicable)

Name	File No.

N.B.—Reports must be accurately and firmly fixed

14th Report

13th Report

12th Report

11th Report

10th Report

9th Report

8th Report

7th Report

6th Report

5th Report

4th Report

3rd Report

Copy

REPATRIATION DEPARTMENT

PATHOLOGY REQUEST AND REPORT

File No. 419654

Surname and Initials	Age	Sex	Name and Address of L.M.O. (OPs. only)	Bed / ~~Chair~~ / ~~Walk~~	Reg'n.	Return to
SUMNER E. L.	70	M	Tel. No.	✓	3626	18

Clinical Notes and Investigation Required:—

Hb. (finger prick)

[illegible] for Dr Banfield
Medical Officer 29/ 11. /1966.

T.49/8.66—C.6859

HAEMOGLOBIN	16·5	gm./100ml.	(M.13.5-18.0) (F.11.5-16.4

Signature [signature] 29/11/1966

Form 83C (Path)
(1966)

HD

Form 83C (Path)
(1966)

Signature / /19

H6

REPATRIATION DEPARTMENT

Form D.878
(1966)

LABORATORY REPORT SHEET

Attach *IN/OUT-PATIENT reports only
* (Delete word not applicable)

Name	File No.

N.B.—Reports must be accurately and firmly fixed

14th Report

13th Report

12th Report

11th Report

10th Report

9th Report

8th Report

7th Report

6th Report

5th Report

4th Report

3rd Report

2nd Report

opy

REPATRIATION DEPARTMENT

PATHOLOGY REQUEST AND REPORT File No. Rwg Hosp regs(?)

ials	Age	Sex	Name and Address of L.M.O. (OPs. only)	Bed / Chair / Walk	Reg'n.	Return to
SUMNER E.L.	71	M	Tel. No.			18

Clinical Notes and Investigation Required:— Gangrenous leg for amp. Respiratory please

Medical Officer 25/11/19 66

T.49/8.66—C.6859

25-11-66

HAEMOGLOBIN	16.5	gm./100ml. (M.13.5-18.0) (F.11.5-16.4)

Form 83 C (Path)
(1966)

Signature / /19

41

Form D.878
(1966)

REPATRIATION DEPARTMENT

LABORATORY REPORT SHEET

Attach *IN/OUT-PATIENT reports only

* (Delete word not applicable)

Name	*File No.*

N.B.—Reports must be accurately and firmly fixed

14th Report

13th Report

12th Report

11th Report

10th Report

9th Report

8th Report

7th Report

6th Report

5th Report

4th Report

3rd Report

2nd Report

1st Report

.6862/66—PL

WD. 18

RED CROSS BLOOD TRANSFUSION SERVICE

Request for Blood Grouping and Transfusion

(To be forwarded to Resuscitation Clinic, Royal Adelaide Hospital)

Patient's blood (5 ml. plain top) must accompany this form. R.G.H. FILE NO

(3 ml. green top) if haemoglobin estimation is required. H. 19654

24 hours' notice should be given whenever possible.

PATIENT'S NAME: Surname SUMNER.
(BLOCK LETTERS)

Christian names EVERETT LUKE

SEX M. AGE 71 HOSPITAL REPATRIATION

DIAGNOSIS [illegible]

DOCTOR [illegible]

Acknowledgement of Request for Blood Grouping and Transfusion

BLOOD GROUP AB Rhesus Pos

Serum has (has not) been reserved (for two weeks). Haemoglobin ....

80601 Bottle(s) of blood have been cross-matched.

For 80778

It (they) will be kept in the Transfusion Lab. labelled with the patient's name until

9 a.m. on ....

Date .... Signed ....

(Blood Transfusion Officer)

RECEIVED
25 NOV

H.L. 89

R
RX R19654

SUMNER. EL.

(PATIENT'S NAME—BLOCK LETTERS) (INITIALS)

WARD 18

SIGNATURE R Paull. SISTER

REPATRIATION DEPARTMENT

Form D 844 (1962)

ANAESTHETIC RECORD SHEET

File No. R19654

Ward No. 18.

INSTITUTION ....

WARD ACTION

NAME OF PATIENT	SERVICE NO.	AGE	WEIGHT
Sumner. E. L.	3626.	70	

RESIDENT MEDICAL OFFICER	DATE OF OPERATION	PERMISSION FOR ANAESTHETIC GIVEN
Dr Thornton.	25/11/66.	[✓] YES [—] NO

URINE	S.G.	ALBUMEN	SUGAR	BLOOD PRESSURE	HAEMOGLOBIN	TEMP.
amber alk.	1012	+	—	165/110	16.5	38

HAS CORTISONE BEEN GIVEN IN THE LAST 18 MONTHS?	PREMEDICATION	EFFECT
[=] YES [?] NO	i.m. Pethidine 100 mgrs. AT 5.20 A.M./P.M. — i.m. Atropine 0.6 mg + Phenergan 50 mg. @ 7.20 pm [illegible]	

ANAESTHETIST	SURGEON
J.R. Barker.	Mervyn Smith.

OPERATION PROPOSED	OPERATION PERFORMED
Amputation L. leg.	✓

TYPE OF PATIENT

[ ] OBESE [ ] THIN [ ] NERVOUS

[ ] PLETHORIC [ ] PHLEGMATIC [✓] AVERAGE

ANAESTHETIC RISK

[ ] GOOD [✓] POOR

[ ] FAIR [ ] DESPERATE

PREOPERATIVE COMPLICATIONS

TO BE COMPLETED IN THEATRE

ANAESTHETIC ADMINISTERED — QUANTITIES GIVEN

[✓] PENTOTHAL 150
N_2O 2:1
[ ] SPINAL
[ ] LOCAL AND REGIONAL

[✓] RELAXANT Scoline 80, Gallamine 40.
[ ] CYCLO
[ ] TRILENE

[✓] FLUOTHANE
[ ] ETHER
[ ] OTHERS

CONDITION OF PATIENT DURING OPERATION

	Systolic	Pulse
8.45		
9	100	82
9.15	100	84

INTRAVENOUS INFUSIONS ADMINISTERED

CONDITION ON LEAVING THEATRE

DRUGS ADMINISTERED POSTOPERATIVELY IN THEATRE

[1.2] ATROPINE [ ] MORPHIA [ ] SEDATIVE [2.5] PROSTIGMIN [ ] PETHIDINE

[ ] OTHERS (SPECIFY) ....

CODE CLASSIFICATION OF ANAESTHETIC PROCEDURES

SUMMARY (including post operative complications related to anaesthesia)

P.G.O.2 Halothane
Scoline for intubation
Gallamine

.... ANAESTHETIST

[P.T.O.

Recovery Room

TIME	PULSE	B.P.	AGENTS ADMINISTERED	REMARKS
9.45.	80	110	Blood. Commenced -	

ANAESTHETIC CHART

CHART CODE

● PULSE
O RESP.
V/Λ B.P.
X ANAES.

260
240
220
200
180
160
140
120
100
80
60
40
20
0

REMARKS

REPATRIATION DEPARTMENT

Form D 848
(1962)

File No. R19,654

SURGICAL OPERATION SHEET

Name of patient (Surname in block letters)	Service No.	Ward
SUMNER E. L.	3626	18

Surgeon	Assistant	Sister
Renwyn Smith	Dr Rumbold	

Operation proposed	Operation performed	Operation code
AK Amputation (L)	→	

DETAILS OF OPERATION

No tourniquet.
Ant + Post flaps fashioned + reflected
Muscle divided, main vessels tied
c̄ silk after dividing thru
atherosclerotic plaques.
Closure of deep fascia c̄ chromic
CG + skin c̄ black silk, with
lat corrugated drains (2).

~~POST-OPERATIVE ORDERS~~

SWABS PACKS AND INSTRUMENTS REPORTED CORRECT
BY Sr Patterson
ANAESTHETIST John Barker

Surgeon [signature] 25 / 11 / 1966

C.6263/62—PL

Form D 841.
(1963).

COMMONWEALTH OF AUSTRALIA.

REPATRIATION DEPARTMENT.

CONSENT FORM FOR ADMINISTRATION OF AN ANAESTHETIC OR PERFORMANCE OF AN OPERATION

CONSENT BY PATIENT.

I hereby consent to undergo the operation of Amputation L. LEG.
(specify operation).

the effect and nature of which has been explained to me by Doctor THORNTON. I also consent to the administration of the necessary local or general anaesthetic and to such further or alternative operative measures as may be found necessary during the course of the operation.

*** I understand that this operation is for diagnostic purposes in connexion with my claim for war pension and that my eligibility for further treatment at the expense of the Repatriation Department is conditional upon the acceptance of my claim.**

Signature of Patient [signature] 25 / 11 /1966.

CONSENT FOR OR ON BEHALF OF PATIENT.

I, ...
(Full name).

of ....
(Full address).

give permission for .... to undergo
(Name of patient).

the operation of .... the effect and nature
(specify operation).

of which has been explained to me. I also give permission for the administration of the necessary local or general anaesthetic and for any further or alternative operative treatment that may be found necessary during the course of the operation.

*** I understand that this operation is for diagnostic purposes in connexion with the claim by the above-named patient for war pension and that his eligiblity for further treatment at the expense of the Repatriation Department is conditional upon the acceptance of his claim.**

Signature .... / /196

Relationship or Capacity ....

* Cross out if not applicable.

4175/65....

By Authority: A. J. ARTHUR, C'wealth Govt. Printer, Canberra.

Form 83B

CASE SHEET

Page 1

Name SUMNER, E.L. Ward No. 18

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
	I think the changes in the L foot are irreversible & agree that AK amputation is indicated.	[signature]
26/11/66	A/K amputation performed last night. Generally satisfactory today, BP 150/90 P 78 fibrillating. Generalised coarse rhonchi all areas. Drip out. Drain out tomorrow. Flat regime & DC [illegible].	[signature]
27/11/66	T 38. Restless, sweating. P 108, irregular - clinically probably fibrillating. [illegible] 5000. Urinary output satisfactory. On digoxin 0.25 mg tds (? just begun 2 days ago).	[signature]
28/11/66	Has not voided since 9.00pm last night. 18 Foley inserted 500 mls concentrated urine obtained. Mental / confused all night.	[signature]

T.1307/8.60—C.3999

Form 83B

CASE SHEET

Page 2

Name SOMNER, E.L. Ward No. 18

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
25/11/66	Records of prior admission Oct/Nov 66 read - fibrillating, insufficient hemiparesis and mild CCF, & signs of peripheral vascular disease. R foot ultimately became gangrenous & an AK amp. was performed by Mr Kenny.	
	Pt has managed at home for past 12/12 wearing pylon apparently until 1/52 ago then foot became painful & swollen and symptoms have increased since c̄ deterioration in supply of limb (see LMO's note)	
	O/E Well nourished aboriginal obviously in pain accentuated by moving his remaining left leg.	
	Eyes - cataractous	
	Neck - no obvious venous engorgement.	
	Heart - AB impalpable. H.S. irregularly irregular no bruits	BP 130/?80
	Variable pulse vol. of HBeat.	
	Lungs - Creps both bases.	
	Abdomen - Obese - no mass or tenderness. Neither femoral pulse palpable.	
	R leg stump ✓	
	L leg - Cold cyanosed & swollen from below knee. Level normally warm AK.	
Hb 16.	Imp ① H.V. [illegible] ② Bld gr[illegible] ③ Amp[illegible]	

T.1307/8.60—C.3999

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

1.

Tailem
Bend

Prescription 25/11/56

N.H.S. P.M.S.

The Admitting Officer,
Repatriation Hospital,
Daw Park,
S.A.

Dear Doctor

Re Mr. Everett Luke
Sumner of whom
we had a phone
discussion early
this afternoon –
This aboriginal

2-

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

~~Prescription~~

~~N.H.S.~~ P.M.S.

man ? aged
71 years apparently
had his right leg
amputated in
your hospital
in February 1965.
(? accuracy of this
date)
He is a service
Pensioner No C 19654
and apparently lives
at Meningie S.A.

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

3.

Prescription

N.H.S. P.M.S.

He presented
himself to Lower
Murray District
Hospital, Tailem
Bend on Sunday
20/11/ ult with
pain and tingling
in left leg.
He is a difficult
historian to assess
but I don't think

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

Prescription

N.H.S. P.M.S.

The pain has
eased him
so much since
being in hospital
However the
right leg below
the knee has become
progressively and
rapidly ~~blue~~ more
bluish in the
past 48 hours – it
has also become
much colder and

6 -

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

~~Prescription~~

~~N.H.S.~~ P.M.S.

all in all there
doesn't appear to
be ~~very~~ any
circulation in the
left leg.
My colleague
Dr. Gooden thought
he could feel a
Thrombus in the
region of femoral
vein (left) high up.

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

Co.

Prescription

N.H.S. P.M.S.

I didn't know
why his right
leg was amputated
and in viewing
this ~~p~~ limb
particularly in
view of the signs
present, we
would appreciate
your admitting
Mr. Sumner for
management.
On admittance

Dr. P. C. GOODEN
Tailem Bend
Surgery Phone 10

Prescription

N.H.S. P.M.S.

to R. M. D. Hospital
he had a moderate
amount of sugar
in urine - but
none since
admittance.

Thank you
for taking this
man

Yours sincerely
Charles Gooden.

DUPLICATE
Form D846 (1964)

REPATRIATION DEPARTMENT

ADMISSION SHEET AND APPLICATION FOR SUSTENANCE ALLOWANCE

FILE No. H 19654

WARD 18

INSTITUTION	NAME (SURNAME IN BLOCK LETTERS)			
(S)	SUMNER Everett L.			
SERVICE No.	HOME ADDRESS			
3626	Meningie S.A.			
AGE	PHONE No.	RELIGION	MARITAL STATE	IF MARRIED, ARE YOU SUPPORTING YOUR WIFE?
12 6 96		Cong	D	

HOW MANY OF YOUR CHILDREN UNDER 16 YEARS ARE YOU SUPPORTING?

ADDRESS OF WIFE AND CHILDREN (IF SAME AS ABOVE, WRITE "AS ABOVE")

NAME AND ADDRESS OF NEXT OF KIN	RELATIONSHIP
Mr Howardson Same	Nephew
	PHONE No.
NAME AND ADDRESS OF EMPLOYER	YOUR OCCUPATION
	S/P
IF UNEMPLOYED, STATE NAME AND ADDRESS OF LAST EMPLOYER	DATE EMPLOYMENT CEASED

Excluding your Repatriation pension, are you or any of your dependants receiving a pension from any other source for a disability arising from war service? If so, give particulars.

No

Excluding child endowment, are you or any of your dependants in receipt of, or have you or your dependants applied for payment of any pension, benefit or allowance from the Department of Social Services? If so, give particulars.

No

NAME AND ADDRESS OF LOCAL MEDICAL OFFICER.

Dr.

1. I declare that I have read the above and that the answers given are true and correct. I am aware that there are penalties for making a false or misleading statement. I acknowledge receipt of a copy of ORDERS AND INSTRUCTIONS of the Institution which I agree to observe.

2. I hereby apply for payment of Sustenance Allowance.

E L Sumner

Signature 25/ 11 /1966

NOTE: Paragraph 2 is to be deleted when the patient is not eligible to apply for payment of Sustenance Allowance.

Admitted at 4.00 ~~a.m.~~ p.m. on 25/ 11 /1966 for treatment and/or investigation of—

Signature of Medical Officer (country) / /196

TRANSPORT ON ADMISSION	STATED PENSION ASSESSMENT	AUTHORITY FOR ADMISSION
St John Amb	SP	
METHOD OF IDENTIFICATION	QUESTIONNAIRE FORWARDED TO EMPLOYER	
F-d1	☐ YES ON / /196 ☐ NO (TICK WHICH)	
FORMS — TO FOLLOW / ATTACHED	SIGNATURE OF ADMISSION CLERK	
	D Scammel 25/ 11 /1966	

BRANCH OFFICE USE

Patient transferred to .... on / /196

Discharged .... on / /196

Form 70 C
(1963)

TRIPLICATE
(For "H" File)

REPATRIATION DEPARTMENT

FILE No. H196524

PRESCRIPTION FORM FOR SURGICAL AIDS, APPLIANCES, ARTIFICIAL REPLACEMENTS AND SPECTACLES.

SURNAME	CHRISTIAN NAMES
SUMNER	EVERETT LUKE

DISABILITY FOR WHICH SURGICAL AID ETC., IS REQUIRED
C.C.F. A/K amputation

PRESCRIPTION FOR (SPECIFICATIONS TO BE STATED BELOW)
1 wheel chair.

	RIGHT EYE				LEFT EYE			
	SPH.	CYL.	AXIS	PRISM	SPH.	CYL.	AXIS	PRISM
DISTANCE								
READING								

SEPARATE PAIRS / BIFOCALS (Strike out which is not applicable)

SPECIFICATIONS:

MEDICAL OFFICER [signature] Bolow

DATE 28/3/66.

FORM 140 RAISED / AMENDED AT R.A.L.F. ON ✓ 29 MAR 1966

FORM 50 No. ...... FORWARDED TO ...... ON ......

FILE COVER ENDORSED ON ......

Form TL 121

REPATRIATION DEPARTMENT — S.A. BRANCH

SOCIAL WORK REPORT

NAME OF PATIENT	FILE NUMBER
SUMNER, E.L.	MX. 19654

Requested by Dr. G. Whyntie.

RE POST-HOSPITAL CARE:

For the last 5 years, Mr. Sumner has lived with his brother's grandson, Howard Sumner at 11 Stakes Crescent, Elizabeth Downs. He does not intend returning there but will live with a nephew, Andrew Sumner, at Meningie, an employee of the local butter factory.
Mr. Sumner is very happy to be going back to his old home town and is agreeable to Social Worker confirming this arrangement with his nephew.

FINANCES:

Has not received the last 2 cheques from his greatnephew at Elizabeth Downs, nor have the family visited for 6 weeks, although previously have visited weekly.
He asked Social Worker to see what was wrong and ask them to send him his money. Meanwhile he is writing to the Deputy Commissioner asking for his next pension to be forwarded to the hospital.

1.3.66 There was no reply to Social Worker's letter to relatives at Elizabeth. Patient seemed hurt about their lack of response and stated he had "given them away".
A letter was forwarded to Mr. A. Sumner at Meningie, seeking confirmation that he would take patient.

Patient has an appointment to attend R.A.L.A.C. today.

3.3.66 Mrs. Sumner, nephew's wife, rang to say that she can take patient home. She wanted to know date of discharge and can be contacted through a neighbour Mrs. Saunders, at Meningie 115.

Social Worker contacted Mrs. Saunders to advise that patient is to attend R.A.L.A.C. on 8.3.66 and that he would probably be discharged shortly after that. Asked that Mrs. Sumner let us know when she can come down.

Later Mrs. Sumner rang.
Her husband finishes work at 3.30 p.m. each day. He has a station sedan and could come and take uncle home in that. Mrs. Sumner stated e/m was a "dear old man" and her husband was his favourite nephew.

11.3.66 Mr. McKinnon, Rehabilitation Officer, advised patient ready for discharge. Patient can wash and dress himself and go to the toilet unaided. He needs help to go to the bath and has been managing in hospital with a bath seat. It would be possible to provide one of these if required and if measurements are forwarded to Rehabilitation Centre.
Social Worker rang Mrs. Saunders - advised patient would be discharged tomorrow and asked that Mrs. Sumner ring to discuss patient.

No further contact from Mrs. Sumner. Patient taken home on 12.3.66.

J Byrnes
(J. BYRNES)
SOCIAL WORKER.

22.3.66

Distribution:
M
H
C
Rehab.

REPATRIATION DEPARTMENT

Form D 876 (1965)

INSTITUTION R.G.H. SPRINGBANK

SUMMARY OF CASE HISTORY

File No. R19654
LCJ:PAV

NAME OF PATIENT	ADDRESS OF PATIENT	AGE
SUMNER, Everett Luke	13 Stakes Crescent, Elizabeth Downs	69

NAME AND ADDRESS OF LOCAL MEDICAL OFFICER

Dr. D.G. Mintz,
21 Hamblynn Road,
ELIZABETH DOWNS

DATE OF ADMISSION 28.9.65

DATE OF DISCHARGE 12.3.66

REFERRED BY Dr. D.G. Mintz.

DIAGNOSIS ON ADMISSION C.C.F. with Vascular insufficiency

R.M.O. Dr. L.C. Jessup

SPECIALIST Mr. Venner

FINAL DIAGNOSIS

Myocardial disease with A/K. amputation right leg.

SUMMARY

HISTORY AND EXAMINATION ON ADMISSION

Admitted with C.C.F. and vascular insufficiency of legs.
On admission he was fibrillating.

RECORD OF TREATMENT AND PROGRESS

On 20.10.65 he developed severe pain in right leg with ischaemic changes - then changes advanced rapidly and A/K. amputation was performed by Mr. Venner on 27.10.65.
His convalescence has been excellent.
He is now able to put on his own leg, dress himself and go to the toilet and it has been arranged for him to stay with relatives at Meningie indefinitely.
We would be grateful if you could follow his progress and treat him as you see fit.
He has bilateral cataract, and glasses will not help him.
Dr. Pyne suggests a ? right lens extraction may help in the future but is not urgent.

TESTS UNDERTAKEN AND RESULTS (where abnormal give particulars)

E.C.G. showed no definite evidence of infarction.
X-ray chest - showed no evidence of lung disease, but the cardiac shadow was enlarged.

CONDITION ON DISCHARGE

RECOMMENDATIONS (Further treatment, medication, convalescence, limitations as to work, rehabilitation programme, etc.)

Dr. W.J.W. Close,
C/- D.B.N.S. Hospital,
Princes Highway,
MENINGIE. S.A.

Dear Dr. Close,

The above copy of summary is forwarded for your information as Mr. Sumner wishes to be placed under your care.

(R.V. SOUTHCOTT) [signature] 14 / 3 /1966
A/Medical Superintendent

FORM 83 F (1959)

REPATRIATION DEPARTMENT

H/HX File No. ....

DISCHARGE SHEET

Name: Sumner. E L

Fit for discharge on	Weight on discharge	Urine analysis made	Blood pressure taken	Chest X-Ray taken
12 / 3 / 1966	stone lbs.	[x] yes [ ] no	[x] yes [ ] no	[x] yes [ ] no

Final diagnosis

1. 1) Myocardial disease

2. 2) ~~[illegible]~~ peripheral Vascular insufficiency of legs.

3) Cataract.

Assessment of accepted disabilities	Assessment of new disabilities

Operations

1. A/K amputation R. leg

2.

Complications

1. Nil

2.

Other disabilities treated during this admission

1. nil

2.

3.

Specialist: Mr Vernon.

Recommendations (future treatment, convalescence, limitation and fitness for work, &c.)

To go to Merangi to Relatives for ~~[illegible]~~ an indefinite period. L.M.O. at Merangi to follow progress.

Instructions to patient

as above

① Dr. Minty
✓ ② Dr (L.M.O.) at Merangi

Sustenance recommended	Transport recommended (car, ambulance)	Summary of case notes to L.M.O.
From To Nil	Taxi Train	[X] yes [ ] no

Signature of Medical Officer	Date
[signature]	12/3/66

Discharged	Occ. Therapy clearance	Library clearance	S.A. 105 clearance
12 / 3 / 1966.	[ ] yes [ ] no	[ ] yes [ ] no	[ ] yes [ ] no

Transport	Warrant No.	Transport provided
[ ] Rail [ ] Bus [ ] Air		[ ] Car [ ] Ambulance

Docket No.	Destination	Approved by

Sustenance form issued .. .. [ ] yes [ ] no		Medical Certificate. Form 71 — 4 raised [ ] yes [ ] no
Form 68 raised .. .. .. [ ] yes [ ] no		For re-admission on / / 19
Form 68 raised .. .. .. [ ] yes [ ] no		For O.P. review on / / 19
Fares *pro forma* raised .. .. [ ] yes [ ] no		Approved by

Signature of Discharge Clerk	Date
G Bennett	14/3/66.

File direction

....

T.1294/6.59—C.2419

FORM D842 (1962)

REPATRIATION DEPARTMENT

WARD NURSING REPORT

FILE No. R19654

MEDICAL OFFICER	WARD No.	BED No.
DR. GOWER. Dr Last.	~~4~~ 6	~~20~~ 16
NAME OF PATIENT	**SERVICE No.**	**DATE OF ADMISSION**
SUMNER. Evrett. LUKE	3626	28. 9. 65
ADDRESS OF PATIENT	**AGE**	**RELIGION**
13 Stakes Cresent. Elizabeth Downs.	69	Cong.

C.D.O. 3171

NAME AND ADDRESS OF NEXT OF KIN: nephew Mr. Howardson same.

TELEPHONE No.: Elizabeth Police WTH.

DIAGNOSIS: Amputee. Chest Pain for Investigation

TEMP (O/A)	PULSE (O/A)	RESPIRATION (O/A)
36.8	60	16

URINALYSIS (O/A): S sugar — Albumin strong S.G. 1020.

WEIGHT:

ITEM	ISSUED	RETURNED
LOCKER KEY	~~20~~ 16	
PYJAMAS		
TOWELS		
D. GOWN		

ORDERS, MEDICATION, NURSING CARE AND ANY ABNORMAL SIGNS AND SYMPTOMS ARE TO BE RECORDED
IRRELEVANT AND INSIGNIFICANT INFORMATION IS NOT TO BE ENTERED

DATE		
28.9.65	Walking admission 2pm in no obvious distress.	83c E.C.G. B.A meal, chest x-ray
	orders ① R.I.B. ② Noludar T or TT Nocte	W/R. C.B.P. E.S.R.
	③ Ward Diet	LFT's S.G.O.T. LDH x3
	Comp urine.	
29.9.65	Satis. N.F.O. w/R slept well No complaints Pulse 64 irregular.	
30-9-65	Good day no complaints	
1.10.65.	Physio to L arm, has definite weakness.	
2.10.65.	Does not feel well worried about his arm. w/R. Slept. Seems depressed	Ba meal
3.10.65.	Better day sat up in solarium this am Tea Toast. 6 am. then Fast for Ba meal 1pm. Ba meal cancelled until Tuesday ?9am.	1pm mon
4.10.65.	Comfortable day L arm still weak. to go to Physio + O.T. daily. Fast B.A. meal at 9.A.M to morrow. Fast from 9 P.M	
5-10-65	To go to O.T. 9.A.M - Thursday. B.A meal completed	
6.10.65	N/S. good night. R. Redmond.	
6.10.65	Not complaining	
7.10.65.	Seems very worried + confused about going to Physio + O.T. requires instruction. digoxin 0.25 mgs. B.D 0. T.D.S Monday	
8.10.65.	Fair day pulse volume soft. + irregular 60	
10.10.65	Fair day c/o aching R leg, cold + blue this am after shower, feels warmer now	
12-10-65	Still c/o severe pain in R. leg. not well enough to go to O.T. today. To Commence Dibenyline 10mgs T 8.A.M daily	83c for E.C.G. X-ray R. Leg
13-10-65	R. Leg still painful, looks rather miserable T.N.E. No further orders.	Friday
14.10.65.	Fair day to be Transferred to Ward 11	

NAME OF PATIENT. Mr Summers

	Wed Tuesday	
15.10.65	Still c/o persisting pain in calf of Rt. leg.	
16.10.65	much the same says he has his clothes [illegible]. [illegible] to ward 4. N/R. Not much sleep c/o pain in calf. Panadol ĪĪ 1am & 6.15 am. [illegible]	
17.10.65	Having pain in legs. N/R. Slept short periods. Still having [illegible] pain in rt leg. Panadol ĪĪ 3am for same.	
18.10.65.	No change.	
19.10.65.	Transferred to Wd. 11. Comfortable. [illegible]	
20.10.65	E/R. Nembutal Ī given on settling [illegible].	
21.10.65	Did not sleep well on sedation given b/c of right leg pains given Panadol ĪĪ 1am c̄ effect. Slept at short intervals thereafter. [illegible]	
21.10.65	May have Doloxene ĪĪ for pain in legs & Nembutal Ī to settle & repeat once if nec. [illegible]	
	E/R. Given Doloxene ĪĪ for pain in legs 9pm & Nembutal 100mgs to settle [illegible].	
	N/R. Very restless until about 1am – c/o of pain in back & left leg. Aspirin tab ĪĪ given with effect. [illegible]	
22.10.65	83c [illegible] L. Linden	
	E/R Nembutal 100 mgms given 9PM not c/o of any pain [illegible]	
23.10.	Good day	
	E/R Nembutal 100mgs given 9 PM. [illegible]	
	E/R Nembutal 100mgs given 9pm.	
25.10.65.	Given Doloxene ĪĪ at 12.30 am for pain in leg. Slept well. [illegible]	
	E/R. Nembutal 100 mgs c̄ Doloxene ĪĪ.	
26-10-65	Seen by Dr Jessup this Am for transfer to WD 18 today	
26.10.65	Seen by Mr. Venner & Dr Kast for amputation rt leg tomorrow P.M. For Match & grouping.	To be shaved tomorrow A.M.
	Blood in AM for B.U.N please. To fast after breakfast tomorrow 4 [illegible] T.P.R	Relatives Notified 5.30pm
	E/R. Glycerine suppositories given c̄out effect 6 & O enema given c̄ good result. Doriden ĪĪ given to settle.	B.U.N [illegible] mgs.
27.10.65	I.V. therapy inserted this AM To O.T. 2 P.M. for B/K amputation	

FORM D842 (CONTINUATION)
(1962)

NAME OF PATIENT. Mr Summer.

27.10.65	R.T.W. 3^{45} pm Conscious & satisfactory, following Above Knee amputation of R. Leg. Moderate amount of oozing through dressing at 8pm – reinforced. IV Therapy satisfactory. Fluids taken. H.N.P.U. Morphia 10mgs 7^{15} pm.	FOR Removal OF DRAINAGE Tube in ~~24~~ 48/HRS. 1. Hourly pulse & BP 2. Morphia 10mgms 4hrly prn 3. IV Therapy 4% dext in 1/5 N/saline.
N/R.	HNV. I.V.T ✓ I.M. Morphia 10mgs given 3-45 AM. B/P 6AM $\frac{160}{100}$ + NE. Wound not oozing.	
28.10.65	Satisfactory post op day No excessive oozing from wound. IV Therapy ceased. B. C. & A. exercises. Supervise same. Sputum dirty. T 37^{5} 80 20	Remove drainage tubes ~~tomorrow~~ P.M.
E/R	T 37^{6}. $\frac{96}{22}$. Help B & C. Expectorating ++. Morphia 10mgs 9pm.	
N/R	Awake at intervals. Slightly disorientated. Slight oozing of bright blood from stump – reinforced. T 36^{8} 72 20	
29.10.65	Drains removed A little disorientated today. Deep breathing & ankle ex. Encourage ↑ fluids	
E/R.	Remains a little disorientated. Reinforced part of dressing this pm.	
N/R	Awake at intervals but quiet. Bed wet @ 4.30 am Sponged. At 5.20 pt apparently jumped over bed rails & fell to floor. Is quite odd "wants his pants has to go" His wound has been oozing serous ooze & there does not appear to be any injury from fall. Reported to N/S Supervisor. R Powell. T 36^{5} $\frac{88}{20}$ irreg	
30.10.65	Very disorientated at times Same treatment. Pulse irregular	
E/R	S/B Dr. Kinlough. Has had Syrup Largactil 50mgms 9pm	
N/R	Slept fairly well. P.48 6am	
31.10.65	Much the same Syr. Largactil 50mgs to settle.	

NAME OF PATIENT. Mr Summer

Date	Notes	Remarks
1-11-65	Unchanged. Syr Largactil 50mgs nocte s.o.s. to settle ✓	
N/	Syrup Largactil 50mgms given 2-40 AM	
	Awake & trying to get out of bed.	
2.11.65.	Remains the same.	
	Syrup Largactil 50 mgms 9 pm	
N/	Slept well.	
3.11.65	S/By Mr. Venner – dressing taken down – satisfactory. Leave until further orders.	
	E/R. Dressing reinforced Coloxyl i given at 9 pm	
3/12 am	Bowels open normal S	
4.11.65.	Redress stump s.o.s. because of oozing.	
E/R	No further oozing. Syr. Larg. 50mg.	
N/	Quiet night.	
5.11.65	Sat out of bed for some hours.	
E/R.	Syr Largactil 50mgs to settle	
N/	Slept well.	
6/11/65	E/R Syrup Largactil 9 pm	
7.11.65.	? Removal of sutures tomorrow	
	E/R. No sedation given – give P.R.N. Sol. Aspirin ii 9 pm	
8.11.65.	Good day. Sitting out of bed.	For Removal Sutures Wed.
	E/R Syrup Largactil 50mgs to settle	
9.11.65	For Transfer to Medical Ward as soon as bed available.	
	Med amt serous oozing from wound 9 pm Syrup Largactil 9 pm	
10.11.65.	To be seen by Mr Venner this P.M.	
	E/R. Not S/B Mr. Venner. Syrup Largactil 50 mgms given to settle.	
11.11.65	Sutures removed. Change dressing daily	To be seen by Eye Specialist
	Sits out of bed daily.	
	Transfer to Wd. 6	
12.11.65	Seen by Dr Pyne at eye clinic this a.m.	
17.11.65	Request sent to Rehab. today.	
1-12-65	Is complaining that his left hip is painful.	
2-12-65	For possible transfer to Wd. 10 next week.	
	Clothes to go with him to O.T. each am.	
	For XRay of (L) hip	

FORM D842 (CONTINUATION)
(1962)

NAME OF PATIENT. Mr Sumner

6. 12-65 For transfer to ward 11 tomorrow
7. 12 65 Transferred to ward 11.
Syrup of Largactil 50 mgs nocte P.R.N.
Bandage Stump daily.
9.12.65 E/R Syrup Largactil 50 mgs 9 p. S/ordered
11-12-65 Needs supervised bathing, able to shower himself & use lavatory. Wheels himself around in chair. Dunkenchele
E/R Syrup Largactil 50 mgs given BH
15/12-65 E/R Syrup Largactil 50 mgs 9 p S/ordered
16-12-65 appointment at RALAC 20-12-65 to be at A+D 12.30 PM. Dunkenchele
E/R Syrup Largactil 50 mg 9 p S/ordered
21-12-65 For Transfer to WD 6 tomorrow.
E/R. Syr. Chlorpromazine 50 mgms given to settle. E.G.
22-12-65 Trans to ward 6. see entry of 11-12-65. Dunkenchele
Encourage Patient to do as much as possible for himself.
23-12-65. May go home for Christmas & Monday 27-12-65.
Will be picked up tomorrow evening 8 pm.
E/R. Pt's relative arrived to take pt. home tonight and to ~~go~~ come back on Sunday night as arranged by phone c̄ Dr Gower.
26/12/65 Patient returned from Pass at 6:30pm.
29-12-65. Pt. to do as much as possible for himself.
7. 1. 66 Slept well. No c/- RR
13. 1. 66 Quiet night - slept well. RR
15-1-66 Slept well
19-1-66 Good night
25-1-66 Slept well
27-1-66 To RALAC. tomorrow. To be at A+D 9am.
28-1-66 Returned from RALAC at 1.15pm. Comfortable
29. 1. 66 good night, no c/- M/S
1/2/66 Slept well no c/- M/S
4/2/66 Slept well no c/- M/S.
4-2-66 To RALAC this morning.
5. 2. 66 Slept w/s
8. 2. 66. To be transferred to wd 11 tomorrow
9-2-66 Transferred in 9.50am. slept soundly S.W.
12. 2. 66 up & about.
E/R. Good evening. Syrup Largactil 50 gms given to settle
slept well S.W.
13. 2. 66 Managed very well over weekend. [illegible]
14-2-66 To Artificial limb clinic at physio depart. 8.50am tomorrow
15-2-66 To RALAC 1 p.m.
E/R. Syrup Largactil 100 mgs.
18-2-66 Slept well. w/s

NAME OF PATIENT. SUMNER.

	E/R Syrup Largactil 50 mgs + Colorly c Drm thom 9 p Jordan
19.2.66	Slept well N/S.
	Syrup Largactil 50 mg at 9 30 pm.
20.2.66	Slept well. N/R.
22.2.66.	Good day.
23.2.66	C/o severe headache 4.55 pm, profuse skin action, skin cold & clammy. T 35° pulse 74 soft & irregular. Seen by Dr. Whyte 5 pm Recovered by 6pm. Dr Kinlough called to see pt & report given to her. Aspirin tabs ii 9pm. Syrup Chlorpromazine omitted
24.2.66	Satisfactory, not c/o any pain or discomfort. MG.
	E/R. Panadol i for headache 9 p. Syrup Chlorpromazine 50 mg Jordan
25.2.66	Not c/o any discomfort.
27.2.66	E/R. Syrup Chlorpromazine 50 mg 9 pm Jordan.
28.2.66	To attend RALAAC Clinic at physio 8.50am tomorrow Dunkinchele
	E/R. Syrup Largactil 50 mg Panadol i 9 p Jordan
1.3.66	Went to RALAAC this PM. Dunkinchele
	E/R. Syrup Largactil 50mgs. Panadol i 9pm P.B.
2.3.66	E/R. Codasol ii Syrup Largactil 50mg 9 p. MR.
	N/R. Slept Well.
3.3.66.	E/R. Syr. Largactil. 50mgs. P.B.
	N/R Slept Well
4.3.66	Required at RALAC. 11 Am Tues. 8.3.66
	A+D 10.30pm. MG.
7.3.66	Slept N/S.
	To attend. Clinic at Physio c H. File at 8.50 Tuesday & to be at A+D 10.30am to go to RALAC. M Giles
8.3.66	Slept
9.3.66	Slept Well.
10.3.66	Slept Well.
11.3.66	For discharge in morning. File in A+D M Camp.
12.3.66	Slept.
12.3.66.	Discharged Dunkinchele.

HL.309

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

SUMMARY OF CASE HISTORY. File No.: ______

Name of Patient: Sumner E.L. Age 70

Diagnosis on admission: C.C.F c̄ Vascular insufficiency

Final diagnosis: Myocardial disease c̄ A/K amputation R. leg.

Specialists: Mr Venner.

Additional copies required for - ______
(1. Doctors other than L.M.O. always send a courtesy copy to other doctor involved.
(2. Interesting cases file.)

	SUMMARY. (Begin summary - "Thank you for your helpful note sent with patient" - if this applies.)
History and examination on admission. Record of treatment and progress. List all investigations (except those repeated several times). 1. Investigations giving normal results. 2. Investigations giving abnormal results. (Remember L.M.O. may not know the names of tests, normal values or significance of abnormalities.) Conclusion and comments.	admitted 28-9-65 c̄ C.C.F & Vascular insufficiency of legs. On admission he was fibrillating & E.C.G. showed no definite evidence of infarction. X chest :- showed no evidence of lung disease, but the cardiac shadow was enlarged. On 20/10/65 he developed severe pain in R. leg c̄ ischaemic changes — these changes advanced rapidly & A/K amputation was performed by Mr Venner on 27/10/65. His convalescence has been excellent. He is now able to put on his own leg, dress himself & go to toilet and it has been arranged for him to stay c̄ relations at Maningie
Disposal of patient and any follow up arranged, treatment on discharge and any particular advice given patient or relatives, e.g. prognosis or information about a malignant or incurable condition. Always make certain L.M.O. knows how much patient or relatives have been told.	independently. We would be grateful if you would follow his progress & treat him as you see fit. He has bilateral cataract, & glasses will not help him. Medical Officer.
If any comments on entitlements, pension rates or other purely departmental matters are necessary, these are placed at the end of the summary under the heading "Branch Office Note". The Typist does not include these in L.M.O's summary.	Dr Pyman suggests a ? R. lens extraction may help in the future but is not urgent. [signature] 12/1/66

Form 83B

CASE SHEET

Page________

Name Sumner. E. L. Ward No.________

Date	Notes on Treatment and Progress (Please write plainly)	M.O.'s Signature
3 Mar 66.	[illegible] [illegible] [illegible] within on 3/12/66. [illegible] [illegible] to care of [illegible] [illegible] [illegible] on 9 [illegible] 66. He is now independent in most ADL. but will need help with bathing. Can dress himself but on his own [illegible]. An approach has been made to his nephew to see if he can live with him. If not ? Eventually Nursing Home not necessary	[illegible]
8/3/66	Seen at clinic today – to RALAC at 10:30 a.m. for fitting of new shoes (These had to be brought in). As far as his RALAC training is concerned, he is ready for discharge. He should come in to Physio. 3 times per wk. for follow up training for 2/52 c̄ review at RALAC clinic then.	B. Hartshorne.
12/3/66	Discharged today. Convey to home	[illegible]

T.1307/8.60—C.3999

.16.

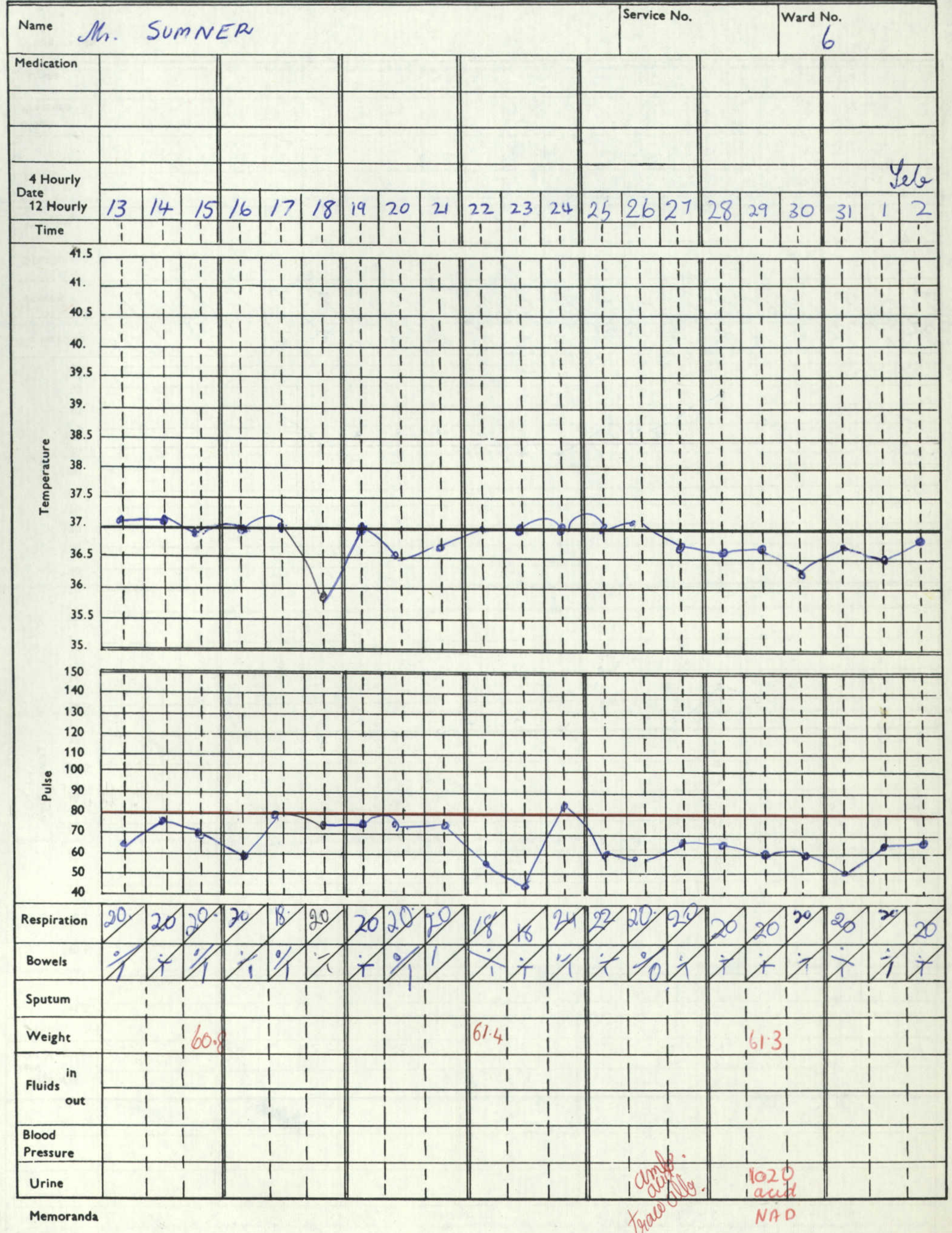
FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. ....

TEMPERATURE CHART

Commenced on 13 / 1 / 1966



PLEASE USE BOTH SIDES

16

FORM 182 (1960)

REPATRIATION DEPARTMENT

File No. R19654

TEMPERATURE CHART

Commenced on / /19

Name: MR SUMNER

Service No. 3626

Ward No. 6

Medication

Dec 23

4 Hourly Date 12 Hourly	23	24	25	26	27	28	29	30	31	Jan '66 1	2	3	4	5	6	7	8	9	10	11	12
Respiration	20				20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Bowels					-/1	+	-/1	-/1	-/1	0/1	-/1	-/1	-	-/1	0/1	T	-/1	0/1	-/1	-/1	-
Sputum																					
Weight										60.3							60.3				
Fluids in																					
Fluids out																					
Blood Pressure																					
Urine									31: Pale amber 1025 NAD									9: pale amber 1030 acid NAD			

Temperature (35.–41.5), Pulse (40–150): W.C.

Memoranda

56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES

16.

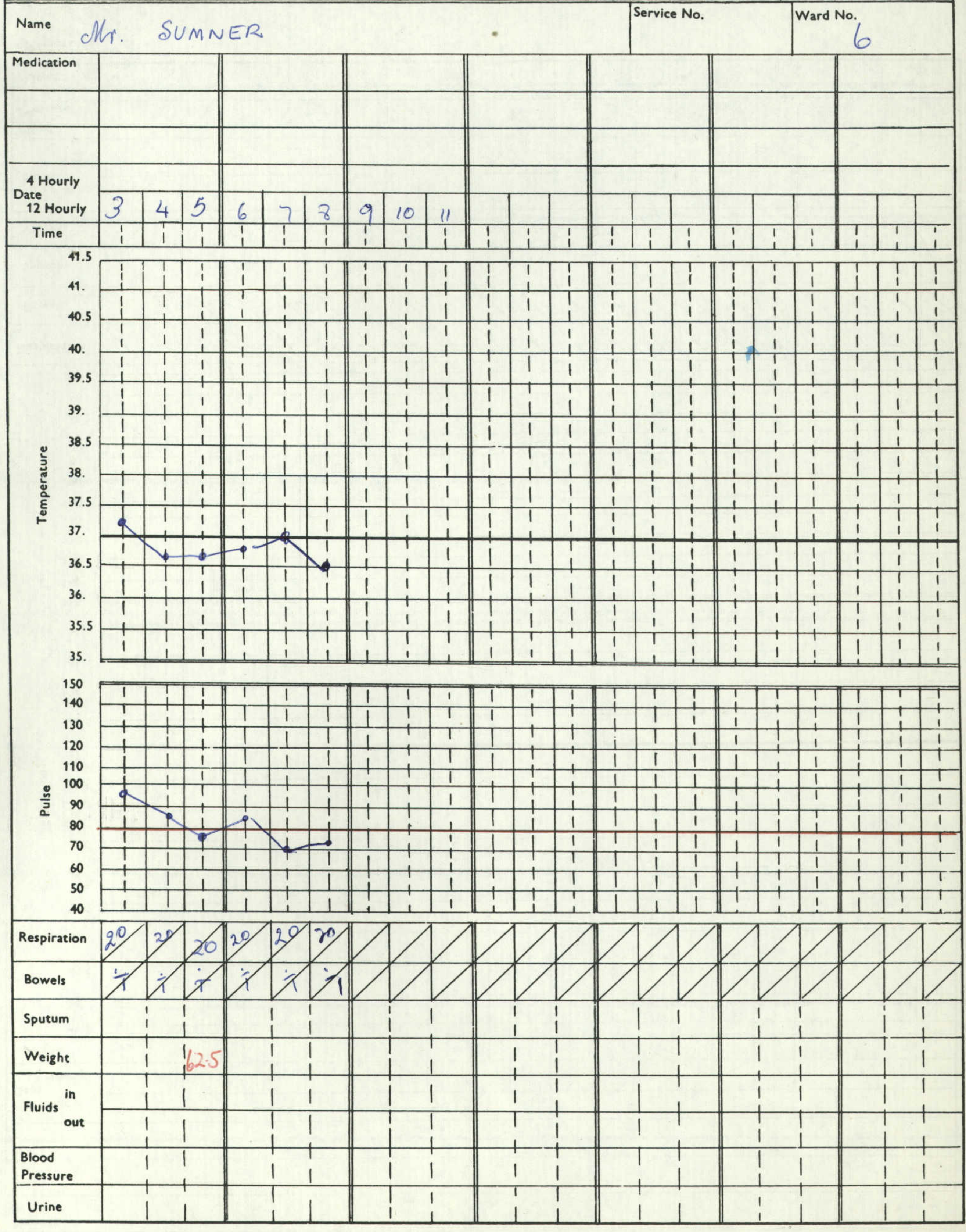
FORM 182 (1960)

REPATRIATION DEPARTMENT

File No. ....

TEMPERATURE CHART

Commenced on 3 / 2 /1966



Memoranda

56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES

Form 83B

CASE SHEET

Page

Name Sommer [handwritten] Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
	When that ward closed for Xmas. Will return to Wd. 4 when it reopens. At present well & attending rehab daily. No therapy required	[signature]
8/2/66	Pylon 1" to high — reduce height by 1½" to give ½" clearance. Should then be fairly satisfactory To clinic next wk.	B. Hartshorne.
23/2/66.	4.55. C/o pain R side of head. c̄ Cold. sweaty. Pulse 74 irregular Temp 35.4. B/P 140/90. No abnormal reflexes. No pain other than R side of head. Obvious. Rept to duty MO. (Dr Kirby) who will see at 6.0 pm.	[signature]
1/3/66	Lt. shoe too tight, to RALAC this p.m. for attempt to fit better fitting shoe c̄ more toe room & better lacing over instep. — Check in 1/52.	B. H. H.

T.1307/8.60—C.3999

Form 83B

CASE SHEET

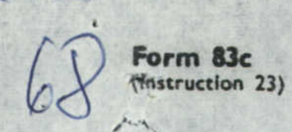
Page________

Name Durward R. Ward No.________

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
12/12/65	Is progressing well. Can walk on crutches but is not safe on his own. Independent in all [illegible]	[signature]
21/12/65	Has not yet [illegible] his position. Doubtful this he is not safe to walk alone under supervision [illegible] not fit for [illegible]. For transfer to Ward 6 tomorrow. Please keep him as active & independent as possible.	[signature]
29.12.65.	Keeping as active & independant as possible	[signature]
11-1-66.	Remains well.	[signature]
18-1-66	Remains well: attending physio daily	[signature]
25-1-66	No change in condition. Physio satisfied c̄ progress	[signature]
28-1-66.	Interim Summary. Refer interim Summary 3-12-65 Transferred from Rehab ward to Wd 6	

T.1307/8.60—C.3999

9.2.66. To be transferred back to Rehab. ward



Form 83c
(Instruction 23)

Dr Wilkinson

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

INSTITUTION .... *DEPARTMENT *SPECIALIST xRay.

Surname SUMNER Christian Name EL

Regt. No. 3626 Rank Unit Age 69

Receiving Treatment for Amputee -

Physician or Surgeon in Charge of Case Dr LAST. Ward No. Rehab ward.

Object of Special *Treatment *Examination (Where necessary state cardinal signs and symptoms) XRay L hip
fell & injured L hip
O/E bruising over greater trochanter
Some tenderness pain on wt bearing
not present clinically * Strike one out

Medical Officer 2/XII/65.

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

HIPS: No fracture seen. Mild osteoarthritic change is seen in the hip and sacro-iliac joint.

F. HARRISON
6.12.65

Specialist

Skiagram No.

16.

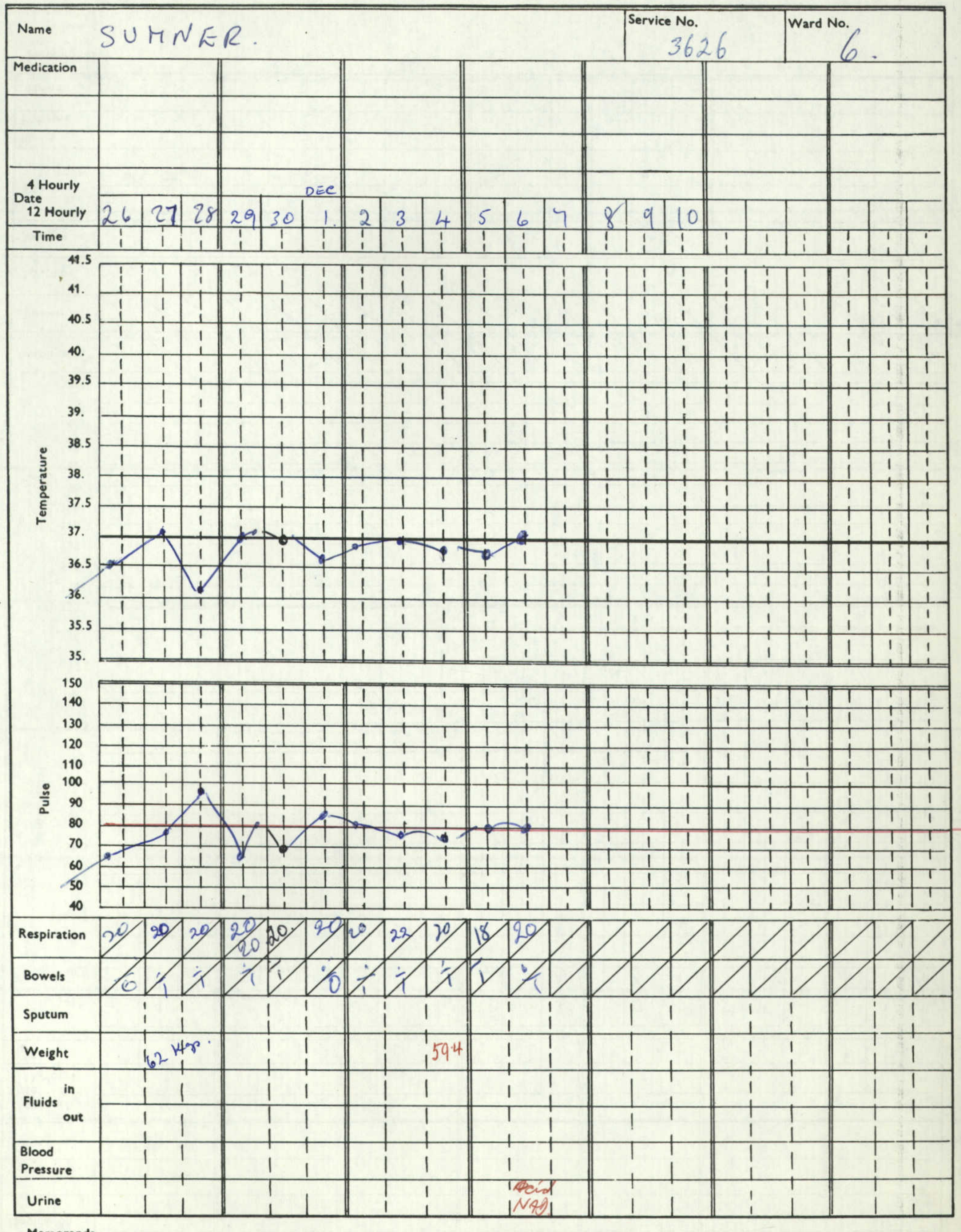
FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. R 19654

TEMPERATURE CHART

Commenced on 26/11/1965



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16

SUMNER.

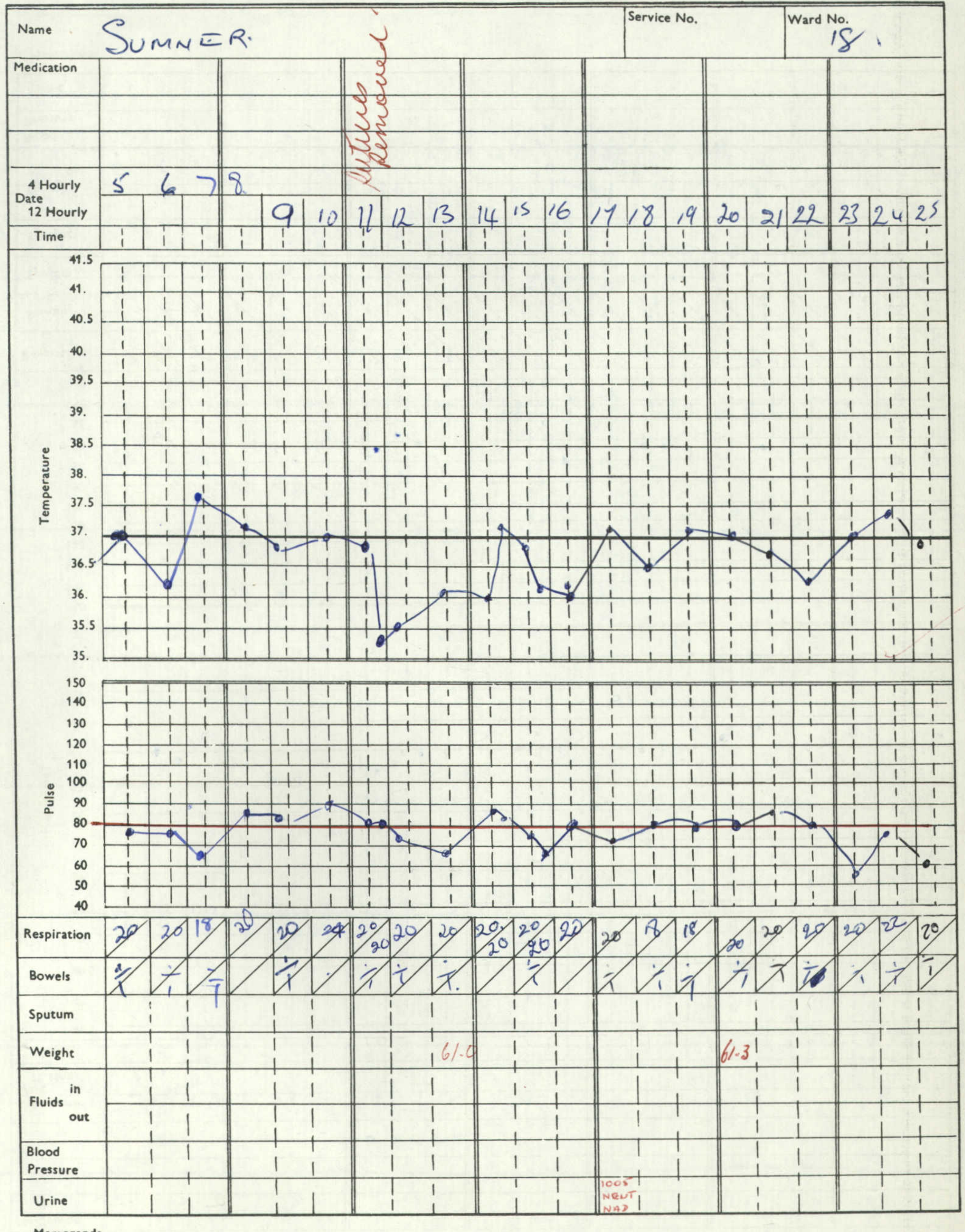
FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. ....

TEMPERATURE CHART

Commenced on / /19



56913/3/62-138,500-O/CH.

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12

FORM 182 (1960)

REPATRIATION DEPARTMENT

File No. ....

TEMPERATURE CHART

Commenced on 27/10/1965

Name	SUMNER	Service No.	Ward No. 18

Medication							
4 Hourly Date 12 Hourly	27	28	29	30	31.	1	2nd. 2 3 4
Time							

Temperature: 41.5, 41., 40.5, 40., 39.5, 39., 38.5, 38., 37.5, 37., 36.5, 36., 35.5, 35.

Drain ape Tube Removed.

Pulse: 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

Respiration: 18, 18, 18, 24, 26, 20, 20, 22, 20, 20, 20, 20, 20, 20, 20, 22, 20, 22, 20, 20, 22, 20, 20, 20, 20, 20

Bowels: 1/1, 0/1, 1/0, 0/0

Sputum

Weight

Fluids	27	29	30	31	1	2	3
in	1·21	2.25	2.25	1·99	1·5	2.5	2.4
out	·15	1·2	·045	1·0	1·675	1.675	1·4

Blood Pressure

Urine

Memoranda

56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES

Form 83B

CASE SHEET

Page

Name Sumner E.W. Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
12.11.65.	Vision 6/18 6/9.	
	No lens improves.	
	Reading glasses would be of no value as his good eye is -2.50 myopic. and the reading addition for him is +2.50, which of course gives a plane lens.	
	He has bilateral nuclear sclerosis so that I would like to review him in 6/12 as if his left eye fails him further he would benefit from a right lens extraction.	
	- April 8th '66	[signature]
22-11-65	Physio reports he is making excellent progress	[signature]
3-12-65	Interim Summary	
	Mr Sumner was admitted c̄ atrial fibrillation & mild CCF & with a history suggestive of cerebro vascular insufficiency (See Dr Singhs Summary 20-10-65.)	
	On 26-10-65 he developed gangrene of the left foot & the L leg was amputated	
above the knee	on 27-10-65. by Mr B Venner	
	Post operatively his course has been uneventful.	
Abnormal	Investigations	
	① ECG confirms atrial fibrillation secondary to generalised myocardial disease	
	② Chest X Ray - cardiac enlargement	
	He is now transferred to Rehab unit on no medication	[signature]

T.1307/8.60—C.3999

Pre-med: morphia 10 mg } 1.45 pm
atropine 0.6 mg }
urine:

FORM 58/P51

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

POST OPERATIVE INSTRUCTIONS.

FORM 108

NAME: SUMNER. E.L. RETURN TO WARD NO.: 18.

SURGEON: Mr. Vernon ANAESTHETIST: Dr. Davenport.

ANAESTHETIC USED: P. Fluoth. G & O2 SISTER I/C: Sr. Bracroft.

OPERATION PERFORMED: A/K amputation

POST OPERATIVE INSTRUCTIONS:

1) Routine pulse & BP
2) Morphia 10 mgm 4 hrly PRN
3) I.V. Drip c 4% + 1/5 N Sal at 3 L. in 24 hours
4) Has not had any blood
5) Drainage tube out 48 hours.

DATE: 27/10/65 SIGNED:

(To be completed in the Treatre and accompanies Patient on return to Ward.)

Form MF 49
(1962)

COMMONWEALTH OF AUSTRALIA

REPATRIATION DEPARTMENT

File No. R 19654

Institution RGH

NOTICE OF INJURY TO PATIENT

PART 1—TO BE COMPLETED BY PATIENT

Surname (in block letters): SUMNER.

Christian names: Everett Luke

Private address: 13 Stakes Crescent Elizabeth Downs

Date and time injury occurred: 30 / 10 /1965 at 5.20 a.m. ~~p.m.~~

Where and how did injury occur? Jumped over bedrails & fell to floor.

Description of injury (bruised left ankle, cut right thumb, etc.)
No visible injury & no bleeding from amputation

Names of any Witnesses
1
2

I declare that I sustained the injury in the circumstances set out above and that the particulars shown are true and correct.

Signature of Patient.............................. / /196

PART 2—TO BE COMPLETED BY WITNESSES

I declare that I actually witnessed the circumstances under which the above patient was injured and that the facts as stated above are correct.

Signature of Witness.............................. Designation.............................. / /196
(Sister, Nurse, Patient, etc.)

Signature of Witness.............................. Designation.............................. / /196
(Sister, Nurse, Patient, etc.)

PART 3—TO BE COMPLETED BY MEDICAL OFFICER

The injury sustained is..............................

and is consistent with the cause stated above. **NOTE:** If patient's state of health or physical disability contributed in any way to the injury, give particulars below :—

Patient examined on / /196 at a.m. / p.m.

Signature of Medical Officer.............................. / /196

PART 4—TO BE COMPLETED BY MEDICAL SUPERINTENDENT

Remarks (include, if necessary, a statement as to whether the injury was received whilst the patient was making use of facilities for amenities or as prescribed therapy.)

Signature of Medical Superintendent.............................. / /196

70713/4/63-1250-0/D

Form 83B

CASE SHEET

Page

Name Sumner E   Ward No. 18

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
30/10/65	Restless at night. Rx ⓞ Syrup chlorpromazine 50mgm to settle if necessary	[signature]
8/11/65.	S/B Dr Venner wound O.K. leave dressings until next W/R	GADavies
8/11/65.	O.K. for eyetest Friday	GADavies
11/11/65.	Remove all sutures. Go to a medical Ward	GADavies
	On 27/10/65 Mr. B. Venner performed a A.K. amputation Rt leg. No post operative complication. All sutures have been removed. He has been seen by Dr Hawthorne On no specific therapy Transfer to Ward 6.	GADavies

T.1307/8.60—C.3999

Form 83c
(Instruction 23)

Urgent

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

INSTITUTION G. *DEPARTMENT *SPECIALIST Path

Surname Summer Christian Name E.L.

Regt. No. 3626 Rank Unit Age 69

Receiving Treatment for amp of leg 27/10.

Physician or Surgeon in Charge of Case Ward No. 18

Object of Special *Treatment *Examination for BUN please
(Where necessary state cardinal signs and symptoms)

L. Goerecke for Dr. Jessup
Medical Officer
26/10/65

* Strike one out

CLINICAL REPORT (Specialist or Department) 27 OCT 1965
(Please write clearly)

BLOOD UREA NITROGEN: 15 mg./100 ml.

[signature]

Specialist

Skiagram No. B557

R

RX 19654

SUMNER. E. L.

(PATIENT'S NAME — BLOCK LETTERS) (INITIALS)

WARD 18.

SIGNATURE E A Gray. SISTER

REPATRIATION DEPARTMENT

Form D 844 (1962)

ANAESTHETIC RECORD SHEET

File No. R19654

Ward No. 18

INSTITUTION RGH

WARD ACTION

NAME OF PATIENT	SERVICE NO.	AGE	WEIGHT
SUMNER. E.L.	3626	69 yrs.	

RESIDENT MEDICAL OFFICER	DATE OF OPERATION	PERMISSION FOR ANAESTHETIC GIVEN
Dr Jessup	27.10.65	[x] YES [ ] NO

URINE	S.G.	ALBUMEN	SUGAR	BLOOD PRESSURE	HAEMOGLOBIN	TEMP.
acid	1010	trace	—	140/80		

HAS CORTISONE BEEN GIVEN IN THE LAST 18 MONTHS?	PREMEDICATION	EFFECT
[ ] YES [x] NO	IMI. Atropine 0.6mgm Morphine 10mgm AT 1.45 P.M.	

ANAESTHETIST	SURGEON
Davenport	Mr B Venner

OPERATION PROPOSED	OPERATION PERFORMED
mid thigh Amputation R leg	Ditto

TYPE OF PATIENT

[ ] OBESE [ ] THIN [ ] NERVOUS

[ ] PLETHORIC [ ] PHLEGMATIC [x] AVERAGE

ANAESTHETIC RISK

[ ] GOOD [x] POOR

[ ] FAIR [ ] DESPERATE

PREOPERATIVE COMPLICATIONS

Congestive cardiac failure
Atherosclerosis.

TO BE COMPLETED IN THEATRE

ANAESTHETIC ADMINISTERED

[x] PENTOTHAL N_2O [ ] SPINAL [ ] LOCAL AND REGIONAL

[ ] RELAXANT [ ] CYCLO [ ] TRILENE

[x] FLUOTHANE [ ] ETHER [ ] OTHERS

QUANTITIES GIVEN

thiopentone 250mgs

CONDITION OF PATIENT DURING OPERATION

Satis

INTRAVENOUS INFUSIONS ADMINISTERED

4% D in N/5 saline

CONDITION ON LEAVING THEATRE

DRUGS ADMINISTERED POSTOPERATIVELY IN THEATRE

[ ] ATROPINE [ ] MORPHIA [ ] SEDATIVE [ ] PROSTIGMIN [ ] PETHIDINE

[ ] OTHERS (SPECIFY) ....

CODE CLASSIFICATION OF ANAESTHETIC PROCEDURES

SUMMARY (including post operative complications related to anaesthesia)

J Davenport
ANAESTHETIST

[P.T.O.

REPATRIATION DEPARTMENT

Form D 848
(1962)

File No. R19654.

SURGICAL OPERATION SHEET

Name of patient (Surname in block letters)	Service No.	Ward
SUMNER E.L.	3626	18

Surgeon	Assistant	Sister
B Vernon	L Jessup	

Operation proposed	Operation performed	Operation code
Rt Above Knee Amputation	Same	

DETAILS OF OPERATION

Using a pneumatic tourniquet on the thigh, & Esmarch bandage below, a circular amputation was performed at the site of election. The femoral vessels were occluded by recent thrombus.

After haemostasis & trimming of skin flaps, the deep fascia & skin were sutured around a tube drain.

~~POST OPERATIVE ORDERS~~

SWABS PACKS AND INSTRUMENTS REPORTED CORRECT

BY BV

ANAESTHETIST J Davenport

Surgeon B Vernon. 27 / 10 / 1965

C.6263/62—PL

Form D 841.
(1963).

COMMONWEALTH OF AUSTRALIA.

REPATRIATION DEPARTMENT.

CONSENT FORM FOR ADMINISTRATION OF AN ANAESTHETIC OR PERFORMANCE OF AN OPERATION

CONSENT BY PATIENT.

I hereby consent to undergo the operation of Amputation of (specify operation). Right Leg the effect and nature of which has been explained to me by Doctor Jessup I also consent to the administration of the necessary local or general anaesthetic and to such further or alternative operative measures as may be found necessary during the course of the operation.

*** I understand that this operation is for diagnostic purposes in connexion with my claim for war pension and that my eligibility for further treatment at the expense of the Repatriation Department is conditional upon the acceptance of my claim.**

Signature of Patient E L Summers 26/10/1965.

CONSENT FOR OR ON BEHALF OF PATIENT.

I,...
(Full name).

of...
(Full address).

give permission for ....to undergo
(Name of patient).

the operation of..the effect and nature
(specify operation).

of which has been explained to me. I also give permission for the administration of the necessary local or general anaesthetic and for any further or alternative operative treatment that may be found necessary during the course of the operation.

*** I understand that this operation is for diagnostic purposes in connexion with the claim by the above-named patient for war pension and that his eligiblity for further treatment at the expense of the Repatriation Department is conditional upon the acceptance of his claim.**

Signature.. / /196

Relationship or Capacity..

* Cross out if not applicable.

4175/65....

By Authority: A. J. Arthur, C'wealth Govt. Printer, Canberra.

Form 83B

CASE SHEET

Page

Name SUMNER Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
26 Oct 65	Today this man shows no signs of heart failure. JVP not elevated, lung bases clear. He shows a senile restrictive ventilatory defect due to hypertrophic emphysema. R) 2nd toe is gangrenous & the whole foot is cold. 1. In my opinion he is fit for surgery. 2. BUN should be checked as a matter of urgency & if elevated any procedure should be done under mannitol diuresis, watching for hypokalaemia and resultant arrhythmia, espy. if he is still on digoxin 3. In my opinion sympathectomy is not likely to succeed, although phenoxybenzamine has been given in suboptimal doses and full pharmacological sympathectomy would not have been achieved.	[illegible signature]
26-10-65	The condition has obviously advanced rapidly, with early gangrene of toes Rt foot. Pulses absent below groin Sympathectomy now of little use & amputation, probably below-knee, is indicated	
27/10/65	amputation today (see ops [illegible])	
28/10/65	Satisfactory Minimal oozing from stump. Remove Drip	[illegible signature]

T.1307/8.60—C.3999

1-11-65 - OK

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT R No. 19654.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

REPATRIATION GENERAL HOSPITAL, SPRINGBANK INSTITUTION ~~*DEPARTMENT~~ *SPECIALIST Sir Leonard Lindon.

Surname Sumner Christian Name Everett Luke

Regt. No. 3626 Rank Pte Unit 32 Bn. Age 69

Receiving Treatment for Rehabilitation - Atrial fibrillation

Physician or Surgeon in Charge of Case G. F. Wrights. Ward No. 11

Object of Special ~~*Treatment~~ *Examination (Where necessary state cardinal signs and symptoms) Has a lot of pain R foot & calf - worse after walking - bad at night. Good femoral pulses - I can't feel popliteals.
If as I think this is vascular is sympathectomy indicated?

Medical Officer 22/10/65.

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

25/10/65 = His claudication is almost confined to the R. leg, & sole, with pain in his toes. Pulses of left leg quite good, although left lower leg & foot are cold & cyanosed, but not nearly as much as the R. leg & foot. Oedema & marked cyanosis of R. foot.

I feel that sympathectomy is advisable, if his cardiac condition will permit operation, because I think that gangrene of several toes is imminent.

Obtain medical assessment. Leonard Lindon - Specialist

Tentatively booked for [illegible] 27/10/65

Skiagram No.

Form 83B

CASE SHEET

Page

Name Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
Summary.	This man was admitted with a feeling of numbness in his left hand. He also noticed some inability to perform finer movements c̄ that hand.	
	O/E. BP. 140/80.	
	HS. no audible bruits.	
	But fibrillating.	
	CNS. no motor weakness.	
	Sl. impairment of ~~in~~ coordination.	
Progress. Investigations.	ECG. showed atrial fibrillation	
	Hb. 16.0 G. ESR - 4.	
	WR. -ve.	
	LFTs. within normal limits	
	Chest xrays Ba meal - NAD.	
	He did not notice any further deterioration in his left hand.	
	He was put on Digoxin 0.25 mgm tds.	
	(iii). Tabs Dibenzyline 10mgm bd.	
	He is now transferred to Rehab for further management.	[signature]
25 Oct 65	Getting a lot of pain in R leg after walking. Keeps him awake at night.	
	O/E R leg abt 10° colder than L	
	Femoral pulses R ++ L ++	
	Popliteal R – L +	
	Tibialis R – L +	
	I am sure this is a vascular pain.	
	Rx Venniger [illegible].	
	Doloxene 2 mls	[signature]

T.1307/8.60—C.3999

Caps Pentothal 1 nocte Rx over [illegible] ... 830 to 5 in [illegible]

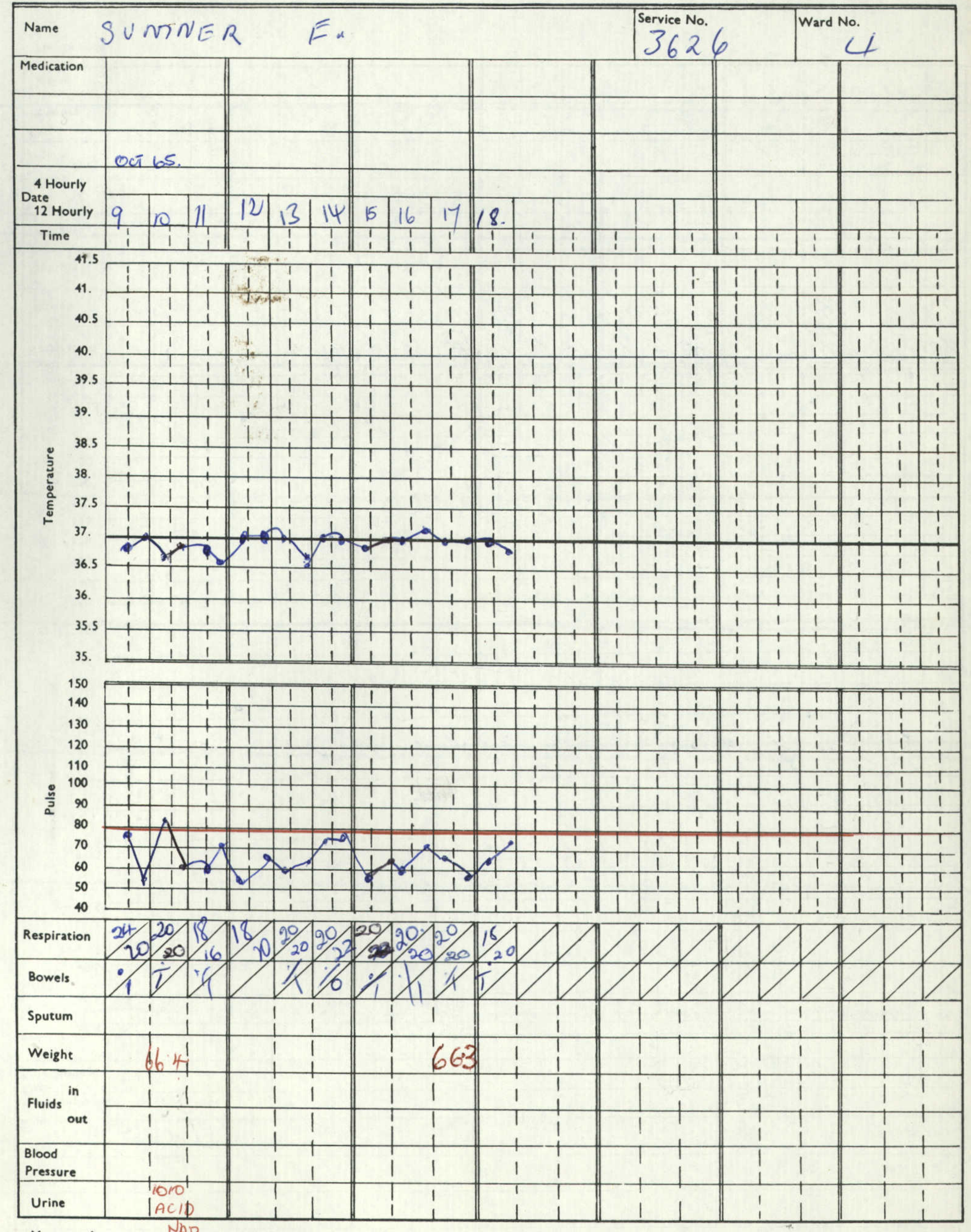
FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. R 19654

TEMPERATURE CHART

Commenced on 28/9/1965



56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES

(20)

FORM 182
(1960)

REPATRIATION DEPARTMENT

File No. R/19654

TEMPERATURE CHART

Commenced on 28/9/1965

Name	SUMNER. EVERETT W.	Service No. 3626	Ward No. 4

Medication

SEPT. Oct 1965.

4 Hourly Date 12 Hourly: 28, 29, 30, 1, 2, 3, 3, 4, 5, 6, 7, 8

Time

Temperature: 41.5, 41., 40.5, 40., 39.5, 39., 38.5, 38., 37.5, 37., 36.5, 36., 35.5, 35.

Pulse: 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

IRREG.

Respiration: 16, 20, 20, 20, 16, 20, 26, 20, 20, 24, 22, 20, 20, 20, 20, 22, 20, 18, 20, 24, 20, 20, 20

Bowels

Sputum

Weight: 665

Fluids in / out

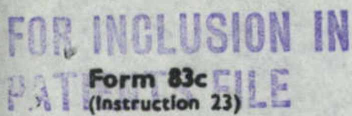
Blood Pressure

Urine: 1010 acid nad.

Memoranda

56913/3/62-138,500-O/CH.

PLEASE USE BOTH SIDES


FOR INCLUSION IN PATIENT'S FILE

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT — R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT — C. No.

INSTITUTION REPATRIATION GENERAL HOSPITAL, SPRINGBANK — *DEPARTMENT *SPECIALIST ECG.

Surname SUMNER. Christian Name E. C.

Regt. No. 3626. Rank Unit Age 69.

Receiving Treatment for I. H. D.

Physician or Surgeon in Charge of Case Single Ward No. 4.

Object of Special *Treatment *Examination ECG.
(Where necessary state cardinal signs and symptoms)

Adm for uncontrolled atrial fibrillation.

Medical Officer 12/10/65

* Strike one out

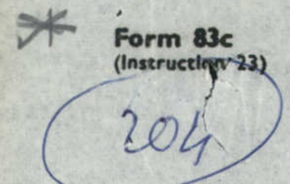
CLINICAL REPORT (Specialist or Department)
(Please write clearly)

13.10.65

Atrial fibrillation is present at an average rate of 90 per minute. Compared with an earlier record taken on 28.9.65 there has been significant diminution in amplitude of the T waves in all complexes and the ST segment shows slight depression and downward concavity. The presence of Q waves in leads 2,3 and aVF raised the possibility of posterior infarction while the appearances are not entirely diagnostic. The record suggests generalized myocardial disease and digitalis may well contribute to the change in appearances over the intervals since the last tracing.

Specialist

Skiagram No.



Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

REPATRIATION GENERAL HOSPITAL, SPRINGBANK

INSTITUTION

*DEPARTMENT X-RAY.
*SPECIALIST

Surname SUMNER. Christian Name E. L.

Regt. No. 36226 Rank Unit Age 69.

Receiving Treatment for I.H.D.

Physician or Surgeon in Charge of Case Singh. Ward No. 4.

Object of Special *Treatment *Examination
(Where necessary state cardinal signs and symptoms)

X-ray Rt leg + foot.
? Bl. vessel calcification

Medical Officer 12/10/65

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

RIGHT LEG: There is some calcification in the left leg in the region of the adductor canal. No calcification is seen in the right leg. Do you want us to do an arteriogram?

Specialist

13 OCT 1965

Skiagram No.

FOR INCLUS[illegible] IN
PATIENTS F[illegible]E

REPATRIATION GENERAL HOSPITAL : SPRINGBANK

12·10·65

H.L. 238

Patient's Name [illegible]R. E.L. SUMNER

Ward No. 4

Date

L1 L2 L3 L3 drop

AVR AVL AVF AVF drop

RV4 V1

V2 V3 V4

V5 V6 V7

MAKER'S NO. 527

[illegible]O. 527

Form 70 A
(Instruction 78)

REPATRIATION DEPARTMENT

DUPLICATE

PRESCRIPTION FORM

No. 77981

Institution

Name SUMNER E. Ward 4

Reg. No. 3626 Rank Unit

PRESCRIPTION	REPEATS	
	Date	Initials of M.O.
R/ Dibenzyline 10 mgm daily ✓		

Medical Officer.

12/10/1965

Dispenser's Initials 12/10/1965

T.1266/6.58—C.4316

N/R

Tues
W/N 0900 5 Oct. ~~1300 4/10~~

Form 83c
(Instruction 23)

72

REPATRIATION DEPARTMENT

R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT

C. No.

INSTITUTION

*DEPARTMENT
*SPECIALIST X-ray.

Surname SOMNOR Christian Name EL

Regt. No. 3626 Rank Unit Age 69

Receiving Treatment for Atrial fibrillation

Physician or Surgeon in Charge of Case Gauen Ward No. 4

Object of Special *Treatment *Examination Ba meal Chest x-ray
(Where necessary state cardinal signs and symptoms)

also complains of indigestion on lying down
? Hiatus hernia.

Medical Officer 29/9/65.

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

CHEST: There is moderate generalized cardiac enlargement. The lungs appear clear.

BARIUM MEAL: The oesophagus was normal but there was slight intermittent reflux although no definite hiatus hernia was demonstrated. No abnormality was revealed in the stomach or duodenum.

A. ROWE
5.10.65

Specialist

Skiagram No.

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT

R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT

C. No.

INSTITUTION

*DEPARTMENT Path
*SPECIALIST

Surname SUMNER Christian Name E C

Regt. No. 3626 Rank Unit Age 69

Receiving Treatment for [illegible]

Physician or Surgeon in Charge of Case Gower Ward No. 4

Object of Special *Treatment *Examination ~~[illegible]~~ ~~[illegible]~~ ~~[illegible]~~
(Where necessary state cardinal signs and symptoms) SGOT & LDH x 3

[signature]
Medical Officer 27/9/65

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

29 SEP 1965

29/9/65 Serum G-O. Transaminase .... 30 Sigma-Frankel units/ml. (Normal 8-40)
L.D.H. = 420 [Normal 200-500]

30/9/65 Serum G-O. Transaminase .... 16 Sigma-Frankel units/ml. (Normal 8-40)
L.D.H. = 420 units/ml.

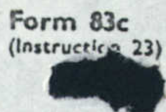
1/10/65 Serum G-O. Transaminase .... 18 Sigma-Frankel units/ml. (Normal 8-40)
L.D.H. = 420 units/ml.

[signature]

Specialist

Skiagram No.

Form 83c
(Instruction 23)



REPATRIATION DEPARTMENT   R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT   C. No.

INSTITUTION .... *DEPARTMENT / *SPECIALIST Path

Surname Sumner   Christian Name E C

Regt. No. 3626   Rank   Unit   Age 69

Receiving Treatment for [illegible]

Physician or Surgeon in Charge of Case Gower   Ward No. 4

Object of Special *Treatment / *Examination ~~[illegible]~~ ~~[illegible]~~ LFTs
(Where necessary state cardinal signs and symptoms) ~~[illegible]~~ x 3

[signature]
Medical Officer 28/9/65

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

29 SEP 1965

LIVER FUNCTION TESTS	NORMALS
1. Serum Bilirubin ... 0.5 mg./100 ml.	0.1 - 0.8
2. Serum Alkaline Phosphatase 8 King-Armstrong units/100 ml.	3 - 13
3. Zinc Sulphate Turbidity ... 8.5 turbitity units	2 - 6
4. Serum G. P. Transaminase ... 4 Sigma-Frankel units/ml.	5 - 35
5. Serum Total Protein ... 7.2 %	6.0 - 8.5
6. Bromsulphalein Test ...	
Retention of dye after 45 minutes — %	less than 5%
7. Urinary Bilirubin ... Neg	
8. Urinary Urobilinogen ... Neg.	

[signature]

1.10.65
Specialist

Skiagram No.

The Institute of Medical and Veterinary Science

Box 14, Rundle Street P.O., Adelaide

TO BE COMPLETED BY SENDER

Sender: Dr. Medical Supt.

Sender's address REPATRIATION GENERAL HOSPITAL, SPRINGBANK

Patient's name SUMNER E.C.

SEROLOGICAL REPORT

No. 2300/1965 30 AUG 1965, 19

The specimen of ~~Blood/C.S.F.~~ Serum gives a

NON-REACTIVE Wassermann reaction

NON-REACTIVE Kahn test

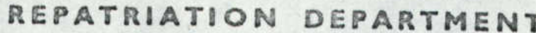
NON-REACTIVE Kline test

Signature R. G. Bruden[illegible]

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT

R No.



TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT

C. No.

INSTITUTION .... *DEPARTMENT / *SPECIALIST Path

Surname Sumner Christian Name E C

Regt. No. 3626 Rank ...... Unit ...... Age 69

Receiving Treatment for [illegible]

Physician or Surgeon in Charge of Case Gower Ward No. 4

Object of Special *Treatment / *Examination W/R ~~CBC ESR~~ ~~LFTs~~
(Where necessary state cardinal signs and symptoms) SG~~OT & LDH~~ x 3

[signature]
Medical Officer 27/9/65.

* Strike one out

CLINICAL REPORT (Specialist or Department)

(Please write clearly)

29 SEP 1965 29/9.

Specialist

Skiagram No.

FOR INCLUSION IN PATIENTS FILE

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT

R No. ....

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT

C. No. ....

INSTITUTION .... *DEPARTMENT *SPECIALIST ....

Surname SUMNER **Christian Name** E L

Regt. No. 3626 **Rank** .... **Unit** .... **Age** 69

Receiving Treatment for Atrial fibrillation & mild LVF

Physician or Surgeon in Charge of Case Green **Ward No.** 4

Object of Special *Treatment *Examination ECG please
(Where necessary state cardinal signs and symptoms)

admitted c̄ atrial fib. & mild LVF F1
Also has cerebro vascular insufficiency

[signature]
Medical Officer 28/9/65

* Strike one out

CLINICAL REPORT (Specialist or Department)
(Please write clearly)

There is atrial fibrillation at an average rate of 93.
Left axis deviation, semihorizontal position, no rotation
QRS 0.11, QT 0.38.
There are doubtful abnormal Q waves in L3 + aVF, not reflected elsewhere.
T waves are flat in V_6 + V_7.
Conclusion: an abnormal record with atrial fibrillation:
QS complexes in aVF become RS on insp'n: thus there is no definite evidence of posterior infarction.

[illegible]

[signature]

Specialist

Skiagram No. ....

Form 83c
(Instruction 23)

REPATRIATION DEPARTMENT R No.

TREATMENT AND REPORT FORM

SPECIALIST OR SPECIAL DEPARTMENT C. No.

INSTITUTION *DEPARTMENT *SPECIALIST Path

Surname Sumner Christian Name E C

Regt. No. 3626 Rank Unit Age 69

Receiving Treatment for [illegible]

Physician or Surgeon in Charge of Case Gower Ward No. 4

Object of Special *Treatment *Examination ~~[illegible]~~ CBP ESR ~~[illegible]~~
(Where necessary state cardinal signs and symptoms) S~~[illegible]~~ x 3

[signature] Medical Officer 28/9/65

* Strike one out

CLINICAL REPORT (Specialist or Department) 29 SEP 1965
(Please write clearly)

10

Hb 16.0	gm./100ml.(13.5-18.0)	W.B.C. 9,000	/c.mm(4,000-10,000)
R.B.C.	mill./c.mm (4.5-6.5)	NEUT. 45 % 4050	/c.mm(2,500-7,500)
P.C. VOL 51	% (40-54)	LYMPH. 45 % 4050	/c.mm(1,500-3,500)
M.C. VOL	cubicu (76-96)	MONO. 1 % 90	/c.mm(200-800)
M.C.H.C. 31.5	% (32-36)	EOSIN. 8 % 720	/c.mm(40-440)
E.S.R. (WEST). 4	mm. 1 hr. (3-7)	BAS. 1 % 90	/c.mm(15-100)
RETICS	% (0.2-2)	%	/c.mm
PLATELETS	/c.mm(150,000-400,000)		

FILM: -

ERYTHROCYTES, LEUCOCYTES, AND PLATELETS
APPEAR NORMAL

[signature]

30.9.65
Specialist

Skiagram No.

FOR INCLUSION IN PATIENTS FILE

REPATRIATION GENERAL HOSPITAL : SPRIN

28 · 9 · 65.

H.L. 238

Patient's Name Mr E. L. Sumner.

Ward No. 4.

Date

L1 L2 L3 L3 insp

AVR AVL AVF AVF insp

RV4 V1

V2 V3 V4

V5 V6 V7

MAKER'S NO. 527

Form 83B

CASE SHEET

Page

Name Sumner Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
	AE all areas	
	Ht vascular	
	pulsations both lower zones.	
	I. ① Atrial fibrillation c̄ mild LVF. (? myocardial ischaemic origin)	
	② Cerebro vascular insufficiency.	
	This mans race & neurological signs make syphilis a possibility	
	for ① ECG; ② CBP ESR; ③ Chest x Ray; ④ Se W/R.; ⑤ LFTS; ⑥ Pra meal; ⑦ SGOT & LDH x 3	
	Rx. ① R/B; ② Noludar Ī or ĪĪ nocte PRN; ③ Ward diet.	[signature]
30-9-65	Remain ISQ — for physiotherapy to L arm & hand.	[signature]
6/10/65.	Still fibrillating. Pulse rate about 92/min.	
	O/E. LVS - no signs of CF.	Digoxin 0.5 mgm twice daily and then 0.25 mgm tds review. [signature]
12/10/65.	C/o. pain in calves after some walking. Can walk about 200 yds then pain in legs. Relieved by resting.	
	O/E. Rt foot temp. < Lt. foot. Dorsalis pedis / Post. tibial /	
	(1) Intermittent claudication secondary to sclerosis.	Rx. Dibenzyline 10mgm daily
	For. or. Xray Rt leg & foot. -	[signature]

T.1307/8.60—C.3999

* Gynaecomastia +++. ② ECG. -

Form 83B

CASE SHEET

Page

Name Sumnor Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
	as a Lewis gunner – was a shearer after the war – now has pension only	
	O/E	
	A part aboriginal in no distress & who like all aboriginals has no sense of time – A very poor historian	
CVS	JVP ↓ ↓ no ankle oedema BP $\frac{140}{80}$	
	P irreg irreg	
	AB VLICS on MCL.	
	AS – pt fibrillating – no audible bruit.	
	PP. poor but present.	
	L hand a little colder than R.	
CNS	pupils R > L assymetrical	
	both R & L ? ?? Acc	
	reflexes all hyperactive but =.	
	~~Refle~~ Plantars L ↓ R ↑.	
	sensation not altered.	
	Coordination slow but satisfactory.	
	Motor tone ↓ ↓	
	~~no spas~~ No obvious motor weakness	
	Cranial nerves – sl deafness otherwise NAD	
	Fundi – bilat ??	
GIT.	lax abdomen	
	Liver ↓ 2F. tender.	
	Sl tenderness in epigastrium	
	~~no~~ mass felt.	
RS	PN resonant	

T.1307/8.60—C.3999

Form 83B

CASE SHEET

Page

Name Gumner   Ward No.

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
	Has suffered from hypertension for many years.	
	He complains of fluctuating numbness & uselessness of his L hand & arm.	
	Yesterday he had an episode of numbness in his left face & this extended down his ~~R~~ arm to his fingers - He could not use his hand or put it in his pocket etc.	
	He has noticed similar ~~dos~~ turns for several years now ("Long time") & they often involve his R arm & L leg but to a lesser degree.	
General health:		
	Appetite - ave wt - steady - suffers from mild indigestion ~~often~~ in bed at night "breaks wind" often - Bowels reg c̄ opening medicine.	
	Gets dyspnoea c̄ mod exercise - also gets indigestion like pain in the central chest radiating ~~along~~ R arm. no ankle oedema	
	Mict - moderate degree of prostatic symptoms c̄ frequency diff in starting & dribbling.	
	Occasional HA - no dizzy spells - no blackouts or fits.	
P.I	⓪ Hypertension - many years.	
	~~⓪~~	
FH	Knows + nothing about family history.	
SA	Lives c̄ nephew at present - Born	

T.1307/8.60—C.3999

on Pt McLeay Mission - served WW1

DR. DAVID MINTZ
55 1535

19 HAMBLYNN ROAD
ELIZABETH DOWNS

28.9.65

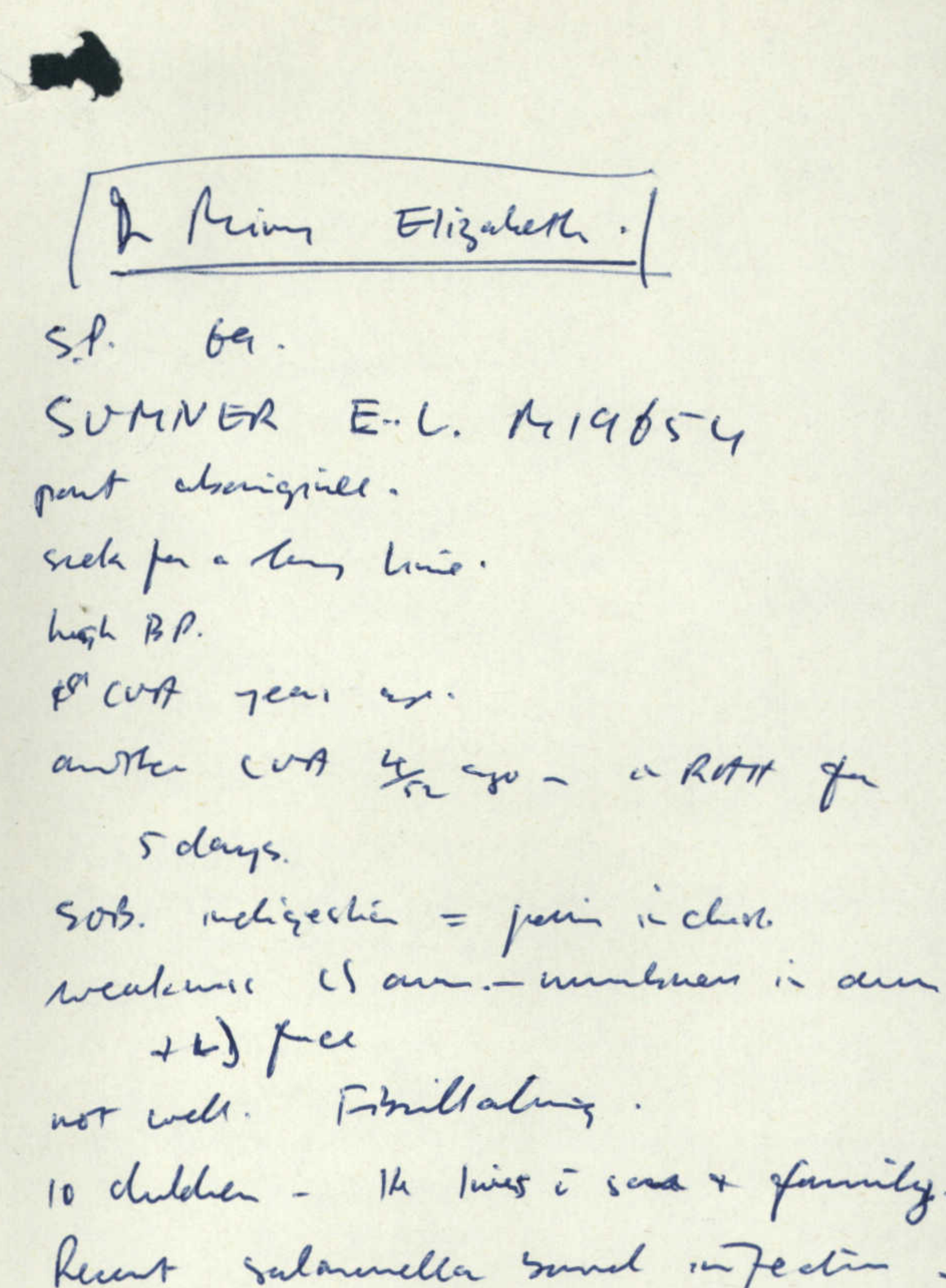
Dear Doctor

Thank you for seeing Mr. E. Sumner File No M 19654. He is 69 yrs old & c/o. Shortness of breath, "indigestion" & weakness in the left arm & numbness in the left side of the face.

He tells me that he has had high blood pressure for many yrs. & had his first CVA many yrs ago - but does not remember how many. 4 weeks ago he had a "turn" in Adelaide & was admitted to RAH for 5 days. - I have no notes about this.

He looks quite si[illegible]
& he is [illegible]:
I feel that he
was [illegible] out a bit
& would be pleased if you
would [illegible] him.

Yours sincerely
Dan[illegible]



Dr Prior Elizabeth.

S.P. 69.

SUMNER E.L. M19654

part aboriginal.

sick for a long time.

high B.P.

1st CVA years ago.

another CVA 4/52 ago – a RAH for 5 days.

SOB. indigestion = pain in chest.

weakness L arm. – numbness in arm + L) face

not well. Fibrillating.

10 children – 1 lives c̄ son + family.

Recent salmonella sound infection – Dept. Health

Probably a close family.

DUPLICATE
Form D846 (1964)

REPATRIATION DEPARTMENT

ADMISSION SHEET AND APPLICATION FOR SUSTENANCE ALLOWANCE

FILE No. R 1965 4

WARD 4

INSTITUTION	NAME (SURNAME IN BLOCK LETTERS)			
RGH5	SUMNER Everett L.			
SERVICE No.	HOME ADDRESS			
3626	~~30~~ 13 Stakes Crescent Elizabeth Down			
AGE	PHONE No.	RELIGION	MARITAL STATE	IF MARRIED, ARE YOU SUPPORTING YOUR WIFE?
12-6-96		Cong	S.	-
HOW MANY OF YOUR CHILDREN UNDER 16 YEARS ARE YOU SUPPORTING?		ADDRESS OF WIFE AND CHILDREN (IF SAME AS ABOVE, WRITE "AS ABOVE")		
-		-		

NAME AND ADDRESS OF NEXT OF KIN	RELATIONSHIP
Mr. Howardson	~~[illegible]~~ Nephew
Same	PHONE No. Police WTM
NAME AND ADDRESS OF EMPLOYER	YOUR OCCUPATION
	S/P
IF UNEMPLOYED, STATE NAME AND ADDRESS OF LAST EMPLOYER	DATE EMPLOYMENT CEASED

Excluding your Repatriation pension, are you or any of your dependants receiving a pension from any other source for a disability arising from war service? If so, give particulars.

NO

Excluding child endowment, are you or any of your dependants in receipt of, or have you or your dependants applied for payment of any pension, benefit or allowance from the Department of Social Services? If so, give particulars.

NO

NAME AND ADDRESS OF LOCAL MEDICAL OFFICER.

Dr. D Mintz Elizabeth Downs

1. I declare that I have read the above and that the answers given are true and correct. I am aware that there are penalties for making a false or misleading statement. I acknowledge receipt of a copy of ORDERS AND INSTRUCTIONS of the Institution which I agree to observe.

2. ~~I hereby apply for payment of Sustenance Allowance.~~

Signature E L Sumner 28 / 9 /1965

NOTE: Paragraph 2 is to be deleted when the patient is not eligible to apply for payment of Sustenance Allowance.

Admitted at 1-45 ~~a.m.~~ p.m. on 28 / 9 /1965 for treatment and/or investigation of—

Signature of Medical Officer .... / /196

TRANSPORT ON ADMISSION	STATED PENSION ASSESSMENT	AUTHORITY FOR ADMISSION
Own	S/P	
METHOD OF IDENTIFICATION	QUESTIONNAIRE FORWARDED TO EMPLOYER	
81	☐ YES ON / /196 ☐ NO (TICK WHICH)	
FORMS — TO FOLLOW / ATTACHED	SIGNATURE OF ADMISSION CLERK [signature] 28 / 9 /1965	

BRANCH OFFICE USE

Patient transferred to .... on / /196

Discharged .... on / /196

Form 70 C (1962)

TRIPLICATE (For "H" File)

REPATRIATION DEPARTMENT

FILE No. R19654

PRESCRIPTION FORM FOR SURGICAL AIDS, APPLIANCES, ARTIFICIAL REPLACEMENTS AND SPECTACLES.

SURNAME SUMNER

CHRISTIAN NAMES E L.

DISABILITY FOR WHICH SURGICAL AID ETC., IS REQUIRED

PRESCRIPTION FOR (SPECIFICATIONS TO BE STATED BELOW)

	RIGHT LEFT EYE				LEFT RIGHT EYE			
	SPH.	CYL.	AXIS	PRISM	SPH.	CYL.	AXIS	PRISM
DISTANCE	-4.00				-2.50	+0.50	90.	
READING								

SEPARATE PAIRS / BIFOCALS (Strike out which is not applicable)

SPECIFICATIONS :

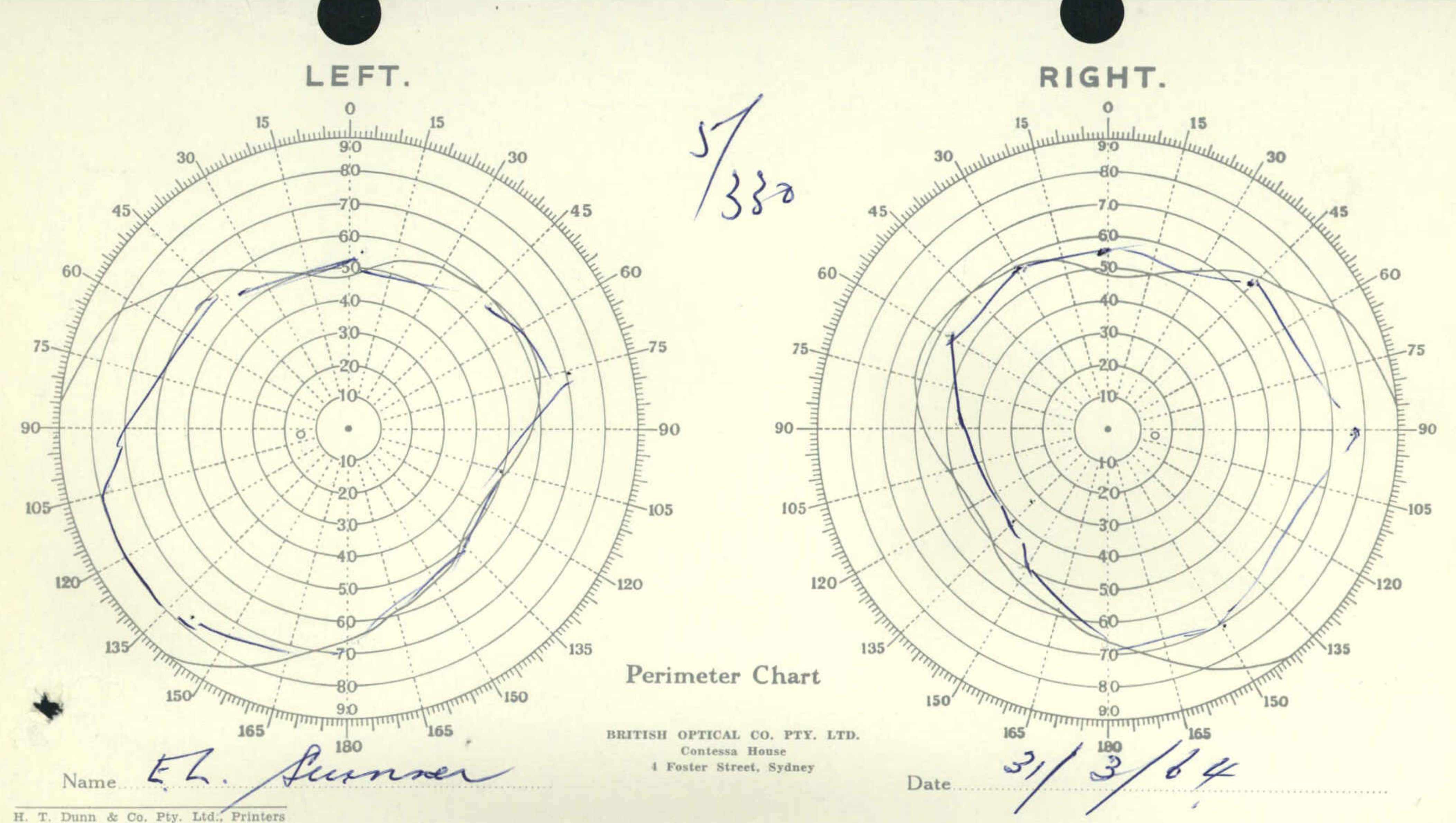
MEDICAL OFFICER Donald Bennett.

DATE 31/3/64

FORM 140 RAISED / AMENDED AT R.A.L.F. ON .... Distance

FORM 50 No. S10570 FORWARDED TO L & P. ON 31-3-64 Item 1a + 3a

H FILE COVER ENDORSED ON 31-3-64. E. Bower.


LEFT.
RIGHT.
57/330
Perimeter Chart
BRITISH OPTICAL CO. PTY. LTD.
Contessa House
4 Foster Street, Sydney
Name E. L. Sumner
Date 31/3/64
H. T. Dunn & Co. Pty. Ltd., Printers

Form 83B

CASE SHEET

Page

Name SUMMER E. L. Ward No. R19654

Date	Notes on Treatment and Progress (Please write plainly)	M.O's. Signature
Dr. Bennett	Never worn glasses	
31-3.64	Distance vision getting worse but is able to read in the distance.	
67 yrs.	V.A. 6/60 6/36-1	
	Subj. -4.00 6/18+2. -2.50 / +0.50 90 6/9+	
	5 g/s reads ·75 M. at 12"	
	Media: Lens sclerosis +++ R&L	
	Fundi. Details not seen	
	Fields. - full	
	Tension R / L 17.5 / 17.5-	
	Bilateral pterygia:	
	Ordered D) glasses.	
		Donald Bennett

T.1307/8.60—C.3999

COMMONWEALTH OF AUSTRALIA

MINUTE PAPER

File No. M 19654

SUMNER, Everett Luke.

Medical Officer-in-Charge
O.P.C. Keswick.

Report from Optometrist on Form 70c of 24/2/64 is referred for your action, please.

G. Lowbond
26/2/64

Eye specialist
[illegible] 28/2/64

Dr Bennett 31-3-64 10.15am

advised
[illegible]

-2 MAR 1964

Form 70 C (1962)

TRIPLICATE (For "H" File)

REPATRIATION DEPARTMENT

FILE No. M19654

PRESCRIPTION FORM FOR SURGICAL AIDS, APPLIANCES, ARTIFICIAL REPLACEMENTS AND SPECTACLES.

SURNAME	CHRISTIAN NAMES
SUMNER	E. L.

DISABILITY FOR WHICH SURGICAL AID ETC., IS REQUIRED

Reg 66 SP

PRESCRIPTION FOR (SPECIFICATIONS TO BE STATED BELOW)

	RIGHT LEFT EYE				LEFT RIGHT EYE			
	SPH.	CYL.	AXIS	PRISM	SPH.	CYL.	AXIS	PRISM
DISTANCE	-275	+1.0	94	3P	-275	+275	87	
READING	Add +275							

SEPARATE PAIRS / BIFOCALS (Strike out which is not applicable)

SPECIFICATIONS:

Vision not satisfactory c best correction.
Medical eye specialist opinion indicated.

Sp 10771

Flockelham

MEDICAL OFFICER Optometrist.

DATE 24/2/64

FORM 140 RAISED / AMENDED AT R.A.L.F. ON ....

FORM 50 No. Sp771 FORWARDED TO L & P ON 17/2/64 [illegible]

FILE COVER ENDORSED ON ....

Reg 66 service Personnel

REPATRIATION DEPARTMENT

FORM U
(1963)

File No. 3626. 32BN.

RECORD OF EVIDENCE

I, Everett Luke SUMNER (Name)

of 28 HOCKING PLACE. ADELAIDE. (Address)

hereby state

I wish to advise that I am a service personnel 68 years of age and I now feel the need of a pair of glasses.
I request that I may have my eyes tested and that I be supplied with glasses.

D/SMO. Eligible Reg 66 SP.
No record of previous eye test. Is there any medical reason why member should not be referred to Laubman & Pank's, please? No. [signature] 12/2/64
M. Lowbond 11/2/64.

The above evidence has been read over by/to me and is true and correct in every particular and I do not wish to make any alterations.

Signature E L Sumner

Witnessed by me at .... this .... day of 196

10.00 on 26/2
~~Dental~~ Spectacles action taken
17/2/64.

Signature of Witness L A Horn

Designation of Witness ORD 10. 2. 64

C.4885/63—PL