Patient 1: Acute Anaphylaxis

- **Patient:** ER-8821-A
- **Gender identity:** F
- **DOB:** 1995-05-12
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Acute anaphylaxis; walnut ingestion.
- **ICD-10 Code:** T78.01XA
- **Vital Signs:** BP 90/60, HR 120, SpO2 91% (Room Air), Temp 98.6°F.
- **Known allergies:** Tree nuts, Peanuts.
- **Pre-existing conditions:** Mild persistent asthma.
- **Medication history:** Albuterol HFA.
- **Treatment received:** 0.3mg Epinephrine (IM), 50mg Diphenhydramine (IV), 1L NS bolus.
- **Medication prescribed:** EpiPen 2-Pak, Prednisone 40mg.
- **Discharge Status:** Discharged Home (Stable).
- **Follow up:** Yes
- **Follow up date:** 2026-02-24
- **Doctor's notes:** Patient responded rapidly to Epinephrine. Observed for 4 hours post-symptom resolution. Educated on cross-contamination risks and the "biphasic reaction" window.

Patient 2: Cardiac Emergency (NSTEMI)

- **Patient:** ER-4409-B
- **Gender identity:** M
- **DOB:** 1962-11-30
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Chest pain; substernal pressure radiating to left arm.
- **ICD-10 Code:** I21.4
- **Vital Signs:** BP 155/95, HR 98, SpO2 96%, Temp 98.2°F.
- **Known allergies:** NKDA.
- **Pre-existing conditions:** HTN, Hyperlipidemia, Type 2 Diabetes.
- **Medication history:** Lisinopril, Atorvastatin, Metformin.
- **Treatment received:** Aspirin 324mg (chewed), SL Nitroglycerin, Heparin drip initiated.
- **Medication prescribed:** Clopidogrel 75mg, Nitroglycerin PRN.
- **Discharge Status:** Admitted to Cardiac ICU.
- **Follow up:** Yes
- **Follow up date:** 2026-02-20

- **Doctor's notes:** ECG showed ST-depression in V4-V6. Troponin I elevated at 0.45. Cardiology consulted for immediate catheterization. Patient's pain level decreased from 8/10 to 2/10 post-Nitro.

Patient 3: Orthopedic Trauma (Fall)

- **Patient:** ER-1052-C
- **Gender identity:** F
- **DOB:** 1948-08-15
- **Date of visit:** 2026-02-16
- **Reason for hospitalization:** Mechanical fall; right hip pain and shortening of the limb.
- **ICD-10 Code:** S72.011A
- **Vital Signs:** BP 130/80, HR 85, SpO2 98%, Temp 97.9°F.
- **Known allergies:** Sulfa drugs.
- **Pre-existing conditions:** Osteoporosis, Osteoarthritis.
- **Medication history:** Alendronate 70mg, Calcium + Vit D.
- **Treatment received:** X-ray, Morphine 2mg IV, Right hip immobilization.
- **Medication prescribed:** Oxycodone 5mg PRN, Senna-S.
- **Discharge Status:** Admitted to Orthopedic Surgery.
- **Follow up:** Yes
- **Follow up date:** 2026-02-18
- **Doctor's notes:** Patient tripped over a loose rug. No loss of consciousness or head trauma. Fracture confirmed via imaging. Surgical intervention (Hemiarthroplasty) scheduled for tomorrow.

Patient 4: False Cardiac Alarm (Panic Attack)

- **Patient:** ER-2029-D
- **Gender identity:** M
- **DOB:** 1988-03-22
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Panic Attack; presented with palpitations and "impending doom."
- **ICD-10 Code:** F41.0
- **Vital Signs:** BP 145/90, HR 112, SpO2 99%, Temp 98.4°F.
- **Known allergies:** None.
- **Pre-existing conditions:** Generalized Anxiety Disorder (GAD).
- **Medication history:** Sertraline (Non-compliant).
- **Treatment received:** ECG (Normal Sinus Rhythm), Lorazepam 1mg PO.
- **Medication prescribed:** Resume Sertraline 50mg, Lorazepam 0.5mg (Emergency use only).

- **Discharge Status:** Discharged Home (Stable).
- **Follow up:** Yes
- **Follow up date:** 2026-02-25
- **Doctor's notes:** Cardiac enzymes were negative. Patient's tachycardia resolved following Lorazepam and calming environment. Referred to outpatient psychiatry for medication management.

Patient 5: False Abdominal Alarm (Gastritis)

- **Patient:** ER-7731-E
- **Gender identity:** F
- **DOB:** 2001-07-09
- **Date of visit:** 2026-02-15
- **Reason for hospitalization:** Epigastric pain; suspected appendicitis vs. gastritis.
- **ICD-10 Code:** K29.70, R10.13
- **Vital Signs:** BP 118/72, HR 78, SpO2 100%, Temp 98.7°F.
- **Known allergies:** Latex.
- **Pre-existing conditions:** None.
- **Medication history:** None.
- **Treatment received:** Physical exam, "GI Cocktail" (Maalox/Lidocaine/Donnatal).
- **Medication prescribed:** Famotidine 20mg PRN.
- **Discharge Status:** Discharged Home (Stable).
- **Follow up:** No
- **Follow up date:** NA
- **Doctor's notes:** Abdomen soft and non-tender on palpation. Symptoms resolved completely within 20 minutes of GI cocktail administration. Advised to follow a bland diet for 48 hours.

Patient 6: Transient Ischemic Attack (TIA)

- **Patient:** ER-5520-F
- **Gender identity:** M
- **DOB:** 1959-01-04
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Sudden onset of right-sided facial drooping and slurred speech; symptoms resolved en route to ER.
- **ICD-10 Code:** G45.9
- **Vital Signs:** BP 170/100, HR 82, SpO2 97%, Temp 98.4°F.
- **Known allergies:** NKDA.
- **Pre-existing conditions:** Atrial Fibrillation (A-Fib), Chronic Kidney Disease (CKD).
- **Medication history:** Apixaban 5mg (admitted to missing several doses), Lisinopril.

- **Treatment received:** CT Head (Negative for bleed), CT Angiogram, Statins, Aspirin 81mg.
- **Medication prescribed:** Resume Apixaban; added Rosuvastatin 20mg.
- **Discharge Status:** Admitted for Neurological Observation.
- **Follow up:** Yes
- **Follow up date:** 2026-02-19
- **Doctor's notes:** Symptoms lasted approximately 15 minutes. "Mini-stroke" diagnosis. MRI scheduled to rule out small infarcts. Patient educated on stroke warning signs (FAST).

Patient 7: Pediatric Asthma Exacerbation

- **Patient:** ER-3312-G
- **Gender identity:** F
- **DOB:** 2018-11-21
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Severe wheezing and "barking" cough; increased work of breathing.
- **ICD-10 Code:** J45.901
- **Vital Signs:** BP 105/65, HR 135 (Tachycardic due to distress), SpO2 89% (on RA), Temp 100.2°F.
- **Known allergies:** Seasonal pollen, Dog dander.
- **Pre-existing conditions:** Childhood Asthma.
- **Medication history:** Albuterol rescue inhaler.
- **Treatment received:** DuoNeb (Albuterol/Ipratropium) x3, Dexamethasone 0.6mg/kg (PO), O2 via nasal cannula.
- **Medication prescribed:** Prednisolone liquid (3-day course), Flovent HFA (Controller).
- **Discharge Status:** Discharged Home (Stable).
- **Follow up:** Yes
- **Follow up date:** 2026-02-19
- **Doctor's notes:** SpO2 improved to 97% post-nebulizer. Minimal subcostal retractions at discharge. Mother provided with an Asthma Action Plan.

Patient 8: Opioid Overdose (Reversed)

- **Patient:** ER-0094-H
- **Gender identity:** M
- **DOB:** 1992-06-30
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Found unresponsive in a public restroom; pinpoint pupils and respiratory depression.

- **ICD-10 Code:** T40.2X1A
- **Vital Signs:** BP 100/55, HR 55 (Bradycardic), SpO2 82%, Temp 97.1°F.
- **Known allergies:** None known.
- **Pre-existing conditions:** Substance Use Disorder (SUD).
- **Medication history:** Unknown.
- **Treatment received:** Narcan (Naloxone) 4mg intranasal by EMS, additional 2mg IV in ER. Bag-valve-mask ventilation.
- **Medication prescribed:** Narcan rescue kit (2 doses), Referral to Social Work/Detox.
- **Discharge Status:** Discharged Home/Against Medical Advice (AMA) once stable.
- **Follow up:** No
- **Follow up date:** NA
- **Doctor's notes:** Patient became combative upon awakening post-Naloxone. Refused further observation or inpatient detox referral. Narcan education provided.

Patient 9: False Emergency (Upper Respiratory Infection)

- **Patient:** ER-1158-I
- **Gender identity:** F
- **DOB:** 2023-04-12
- **Date of visit:** 2026-02-17
- **Reason for hospitalization:** Parent concerned about "high fever" and potential pneumonia. Fever of 101.5°F.
- **ICD-10 Code:** J06.9
- **Vital Signs:** BP 90/60, HR 110, SpO2 99%, Temp 101.4°F.
- **Known allergies:** None.
- **Pre-existing conditions:** None.
- **Medication history:** None.
- **Treatment received:** Acetaminophen (Tylenol) infant drops. Lungs clear to auscultation.
- **Medication prescribed:** Alternating Acetaminophen/Ibuprofen PRN.
- **Discharge Status:** Discharged Home (Stable).
- **Follow up:** No
- **Follow up date:** NA
- **Doctor's notes:** Viral URI (Common Cold). No signs of respiratory distress or consolidation on physical exam. Advised parent on hydration and monitoring for lethargy.

Patient 10: Diabetic Ketoacidosis (DKA)

- **Patient:** ER-6641-J
- **Gender identity:** M
- **DOB:** 2005-09-14
- **Date of visit:** 2026-02-16

- **Reason for hospitalization:** Nausea, vomiting, and "fruity" breath; altered mental status.
- **ICD-10 Code:** E10.10
- **Vital Signs:** BP 105/70, HR 118, SpO2 98%, Temp 99.1°F.
- **Known allergies:** Penicillin.
- **Pre-existing conditions:** Type 1 Diabetes Mellitus.
- **Medication history:** Insulin Glargine, Insulin Lispro.
- **Treatment received:** IV Normal Saline (2L), Insulin Drip (0.1 units/kg/hr), Potassium replacement.
- **Medication prescribed:** Adjusted Insulin sliding scale.
- **Discharge Status:** Admitted to Medical Floor.
- **Follow up:** Yes
- **Follow up date:** 2026-02-23
- **Doctor's notes:** Blood glucose on arrival: 540 mg/dL. Anion gap 22. Arterial blood gas confirmed metabolic acidosis. Patient reports missing doses due to stomach flu.