\*\*Medical Report for Patient 006-115302\*\*

\*\*1. Patient Information\*\*

\*\*\*Patient Unit Stay ID:\*\* 866114 \* \*\*Patient Health System Stay ID:\*\* 650175 \* \*\*Unique Patient ID:\*\* 006-115302 \*
\*\*Gender:\*\* Female \* \*\*Age:\*\* 82 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 164 \* \*\*Ward ID:\*\* 321 \* \*\*Unit Type:\*\*
Med-Surg ICU \* \*\*Unit Admit Time:\*\* 06:28:00 \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Discharge Time:\*\*
02:37:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Time:\*\* 05:55:00 \*
\*\*Hospital Admit Source:\*\* Emergency Department \* \*\*Hospital Discharge Year:\*\* 2014 \* \*\*Hospital Discharge Time:\*\*
01:58:00 \* \*\*Hospital Discharge Location:\*\* Skilled Nursing Facility \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Admission
Weight:\*\* 50 kg \* \*\*Discharge Weight:\*\* 42.5 kg \* \*\*Admission Height:\*\* 158 cm \* \*\*APACHE Admission Dx:\*\* Pneumonia, bacterial

\*\*2. History\*\*

NULL (Insufficient information provided)

\*\*3. Diagnoses\*\*

The patient presented with multiple diagnoses during her ICU stay. The diagnoses, listed in the order of entry, are:

\* \*\*Acute COPD Exacerbation (491.21, J44.1):\*\* This was listed as a primary diagnosis, initially entered 62 minutes after unit admission, and again at 2620 minutes. It was not active upon discharge. \* \*\*Acute COPD Exacerbation (491.21, J44.1):\*\* This was listed as a primary diagnosis, entered at 2620 minutes after unit admission. It was active upon discharge. \* \*\*Pneumonia (486, J18.9):\*\* Entered at 2620 minutes after unit admission. This was listed as an 'Other' diagnosis and was active upon discharge. \* \*\*Sepsis (038.9, A41.9):\*\* Entered at 2620 minutes after unit admission. This was listed as an 'Other' diagnosis and was active upon discharge.

\*\*4. Treatments\*\*

The patient received the following treatments:

\* \*\*Non-invasive ventilation:\*\* This pulmonary treatment was initiated at 1499 minutes post unit admission and was active until 2620 minutes. It was then re-initiated at 2620 minutes and was active upon discharge.

\*\*5. Vital Trends\*\*

The following vital signs were recorded at 58 minutes post unit admission:

\* \*\*Heart Rate (HR) Current:\*\* 89 bpm \* \*\*Heart Rate (HR) Lowest:\*\* 89 bpm \* \*\*Heart Rate (HR) Highest:\*\* 94 bpm \*
\*\*Blood Pressure (BP) Systolic Current:\*\* 96 mmHg \* \*\*Blood Pressure (BP) Systolic Lowest:\*\* 98 mmHg \* \*\*Blood Pressure (BP) Diastolic Current:\*\* 49 mmHg \* \*\*Blood Pressure (BP) Diastolic Current:\*\* 49 mmHg \* \*\*Blood Pressure (BP) Diastolic Lowest:\*\* 59 mmHg \* \*\*Respiratory Rate (Resp) Current:\*\* 28 breaths/min \* \*\*Respiratory Rate (Resp) Lowest:\*\* 28 breaths/min \* \*\*Respiratory Rate (Resp) Highest:\*\* 30 breaths/min \* \*\*Oxygen Saturation (O2 Sat%) Current:\*\* 92% \* \*\*Oxygen Saturation (O2 Sat%) Highest:\*\* 92% \* \*\*Weight (kg) Admission:\*\* 50 kg \* \*\*Weight (kg) Current:\*\* 39 kg \* \*\*Weight (kg) Delta:\*\* -11 kg \* \*\*Intake & Output (ml) Intake Total:\*\* 0 ml \* \*\*Intake & Output (ml) Output Total:\*\* 0 ml \* \*\*Intake & Output (ml) Dialysis Net:\*\* 0 ml \* \*\*Intake & Output (ml) Total Net:\*\* 0 ml \* \*\*Glasgow Coma Scale (GCS) Score:\*\* 13 (Eyes 3, Verbal 4, Motor 6)

\*\*6. Lab Trends\*\*

Multiple laboratory tests were performed at various time points during the ICU stay. Specific trends require further analysis of the time-series data. The data includes values for: Chloride, BUN, Glucose, Bicarbonate, Calcium, Total Protein, ALT, Anion Gap, Hematocrit, MCV, MCH, MCHC, Platelets, WBC, MPV, Lactate, and Magnesium.

\*\*7. Microbiology Tests\*\*

NULL (Insufficient information provided)

\*\*8. Physical Examination Results\*\*

A structured physical exam was performed. Specific details are available in Section 5, Vital Trends.