\*\*Medical Report: Patient 006-100457\*\*

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

\*\*\*Patient Unit Stay ID:\*\* 671292 \* \*\*Unique Patient ID:\*\* 006-100457 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 74 years \*
\*\*Ethnicity:\*\* Other/Unknown \* \*\*Hospital ID:\*\* 165 \* \*\*Ward ID:\*\* 337 \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Admission
Height:\*\* 177.8 cm \* \*\*Admission Weight:\*\* 63.9 kg \* \*\*Hospital Admit Time:\*\* 2015-XX-XX 20:38:00 (Hospital Admit
Offset: -1753 minutes from unit admit) \* \*\*Hospital Admit Source:\*\* Emergency Department \* \*\*Hospital Discharge Year:\*\*
2015 \* \*\*Hospital Discharge Time:\*\* 2015-XX-XX 21:34:00 (Hospital Discharge Offset: 5503 minutes from unit admit) \*
\*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Admit Time:\*\* 2015-XX-XX 01:51:00
\* \*\*\*Unit Admit Source:\*\* ICU \* \*\*Unit Visit Number:\*\* 2 \* \*\*Unit Stay Type:\*\* stepdown/other \* \*\*Unit Discharge Time:\*\*
2015-XX-XX 18:14:00 (Unit Discharge Offset: 983 minutes from unit admit) \* \*\*Unit Discharge Location:\*\* Acute
Care/Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Admission Diagnosis (APACHE):\*\* NULL

## \*\*2. History\*\*

Insufficient information provided to generate a detailed patient history. The provided data lacks information on presenting symptoms, prior medical conditions, family history, social history, and medication history. A comprehensive history is crucial for a complete medical assessment and is therefore NULL in this report.

## \*\*3. Diagnoses\*\*

Insufficient information provided. The admission diagnosis from APACHE is missing. Therefore, the Diagnoses section is NULL.

## \*\*4. Treatments\*\*

Insufficient information provided. No treatment details (medications, procedures, therapies) are available in the provided data. The Treatments section is NULL.

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

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) were included in the provided dataset.

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

The provided laboratory data shows multiple chemistry and hematology tests performed at various time points during the patient's ICU stay. Key observations include:

\* \*\*Electrolytes:\*\* Sodium levels fluctuated between 137 and 139 mmol/L. Potassium levels were consistently around 4.2 mmol/L. Chloride levels ranged from 104 to 110 mmol/L. Bicarbonate levels showed some variation, ranging from 23 to 26 mmol/L. The anion gap remained relatively stable around 6-7 mmol/L. Calcium levels fluctuated between 8.0 and 8.6 mg/dL. \* \*\*Renal Function:\*\* BUN levels varied between 28 and 34 mg/dL, and creatinine levels ranged from 1.20 to 1.31 mg/dL, suggesting some degree of renal impairment. \* \*\*Liver Function:\*\* ALT (SGPT) and AST (SGOT) levels showed elevated values, with ALT ranging from 14 to 52 IU/L and AST ranging from 21 to 52 IU/L, indicating possible liver injury. Total bilirubin levels were slightly elevated (0.2 to 0.3 mg/dL). \* \*\*Hematology:\*\* Hemoglobin levels decreased from 12.2 g/dL to 10.5 g/dL during the stay. Hematocrit showed a corresponding decrease from 35.6% to 30.4%. Platelets showed a wide range from 177 to 239 K/mcL. MPV was consistently around 9.3 fL. RBC and MCV were relatively stable. RDW remained consistently around 13.3%. PT, PTT, and PT-INR all showed elevation, indicating possible coagulation abnormalities. The changes in these values suggest possible underlying conditions or complications. \* \*\*Other:\*\* Total protein levels showed a decline from 6.9 g/dL to 6.5 g/dL and then 7.2 g/dL at the later timepoint. Albumin levels were consistently low, around 2.4 to 2.7 g/dL. Phosphate was measured at 2.7 mg/dL.

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

NULL. No microbiology test results were available in the dataset.

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

NULL. No physical examination findings are present in the provided data.