

## **\*\*Patient Medical Report\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 351525 \* \*\*Unique Patient ID:\*\* 004-12574 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 39 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 125 \* \*\*Ward ID:\*\* 174 \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 2015-XX-XX 17:25:00 (Assuming a date is available from other data not provided) \* \*\*Unit Admit Source:\*\* Floor \* \*\*Unit Discharge Time:\*\* 2015-XX-XX 22:17:00 (Assuming a date is available from other data not provided) \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Time:\*\* 2015-XX-XX 11:28:00 (Assuming a date is available from other data not provided) \* \*\*Hospital Admit Source:\*\* Operating Room \* \*\*Hospital Discharge Time:\*\* 2015-XX-XX 21:32:00 (Assuming a date is available from other data not provided) \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Admission Weight:\*\* 65.54 kg \* \*\*Admission Height:\*\* 170.2 cm \* \*\*APACHE Admission Dx:\*\* Sepsis, GI

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

NULL (Insufficient information provided in the JSON to describe the patient's medical history. A detailed history would typically include presenting complaints, duration of symptoms, relevant past medical history, family history, social history, and medication history.)

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

The patient presented with multiple diagnoses, listed in order of priority:

\* \*\*Primary:\*\* Septic shock (785.52, R65.21) \* \*\*Major:\*\* ARDS (518.81, J80), Pneumonia (486, J18.9), Alcohol withdrawal (291.81, F10.239), Diabetes Mellitus, Hypokalemia (276.8, E87.8), Hypomagnesemia (275.2, E83.42), Peritonitis due to spontaneous bowel perforation (567.9, K65.0), Encephalopathy (348.30, G93.40), Pancreatitis \* \*\*Other:\*\* Hypotension/pressor dependent (recorded both active and inactive during the stay) \* \*\*Note:\*\* Some diagnoses had missing ICD-9 codes.

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

The patient received a comprehensive range of treatments during their ICU stay. Active treatments upon discharge included:

\* Vancomycin (antibiotic) \* Fluconazole (antifungal) \* Bolus parenteral analgesics \* Normal saline administration (fluid bolus) \* Gastroenterology consultation \* CT scan \* Enteral feeds (oral feeds) \* Hypotonic fluid administration \* Continuous parenteral analgesics \* Compression boots (VTE prophylaxis) \* Psychiatry consultation \* Piperacillin/tazobactam (antibiotic) \* IV furosemide (diuretic) \* Oxygen therapy (<40%) via nasal cannula \* Potassium administration \* Magnesium administration \* Intravenous electrolyte administration \* Drainage procedure (surgical) \* Foley catheter \* Lorazepam (sedative) \* Meropenem (antibiotic) \* Ondansetron (antiemetic) \* Acetaminophen (analgesic) \* Sliding scale insulin administration \* Blood culture \* AFB sputum culture \* Chest X-ray

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

NULL (No vital sign data was provided in the JSON.)

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

The provided laboratory data includes several blood tests (hemoglobin, hematocrit, white blood cell count, platelets, etc.) and chemistry tests (sodium, potassium, chloride, bicarbonate, creatinine, glucose, BUN, ALT, AST, albumin, total protein, total bilirubin, ammonia, lactate) performed at various time points during the ICU stay. Bedside glucose levels were also monitored frequently. There is also PT and INR, and PTT. Note that there are multiple entries for many lab tests, indicating

repeated measurements. Analysis of these trends would require time-series visualization to show changes over time. Further analysis would require the actual time series data.

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

Blood cultures and AFB sputum cultures were performed. The results are not provided.

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

Physical exam notes at one point indicated a sinus rhythm, blood pressure (systolic) of 163 mmHg (both current and highest/lowest readings are the same, indicating a single measurement was taken), diastolic blood pressure of 120 mmHg (also with consistent highest/lowest readings), spontaneous respiration mode, and a GCS score estimated as 15(4+4+6) due to medication effects. The patient's admission weight was 65.54 kg.