Patient Information

Patient Unit Stay ID: 361404 Unique Patient ID: 004-11678 Gender: Female Age: 53 Ethnicity: African American Hospital Admission Time: 2015-05-XX 05:59:00 (Hospital Admit Offset: -130 minutes) Hospital Admission Source: Emergency Department Hospital Discharge Time: 2015-05-XX 21:15:00 (Hospital Discharge Offset: 2226 minutes) Hospital Discharge Location: Skilled Nursing Facility Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admission Time: 2015-05-XX 08:09:00 Unit Admission Source: Emergency Department Unit Discharge Time: 2015-05-XX 21:15:00 (Unit Discharge Offset: 2226 minutes) Unit Discharge Location: Skilled Nursing Facility Unit Discharge Status: Alive Admission Height: 162.6 cm Admission Weight: 87 kg Discharge Weight: NULL

Medical History

NULL (No detailed medical history provided in the input data.)

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon discharge was asthma/bronchospasm (ICD-9 codes 493.90, J45). Other significant diagnoses included:

* Multiple sclerosis (ICD-9 codes 340, G35): This diagnosis was listed as 'Major' and was present both upon admission and discharge. * Acute respiratory distress (ICD-9 code 518.82): This was a 'Major' diagnosis, present at both admission and discharge. * Diabetes mellitus: This diagnosis was listed as 'Major' and was present at both admission and discharge. * Hypertension (ICD-9 codes 401.9, I10): This was an 'Other' diagnosis, present upon discharge.

The temporal sequencing of diagnosis entries suggests a complex clinical picture. Multiple diagnoses related to the pulmonary and neurologic systems were entered relatively early in the stay, followed by later entries related to diabetes and hypertension. This may indicate initial focus on respiratory and neurological concerns, with other comorbid conditions identified later in the hospitalization.

Treatments

The patient received various treatments, some active upon discharge and others not. Treatments included:

* Ondansetron (antiemetic): Administered early in the stay, not active at discharge. * Oxygen therapy via nasal cannula: Administered early, not active at discharge. * Foley catheter: Used early in the stay, not active at discharge. * Diazepam (sedative): Administered early, later reactivated and active at discharge. * Coumadin (anticoagulant): Prescribed early, active at discharge. * Bronchodilator: Administered early in the stay, not active at discharge. * Compression boots (VTE prophylaxis): Administered early, and active at discharge. * Losartan (ARB for hypertension): Administered early, not active at discharge. * Oral feeds: Administered early, active at discharge.

The treatments suggest management of symptoms associated with respiratory issues, pain, and potential complications such as VTE. The continued need for diazepam, Coumadin, and oral feeds upon discharge indicate ongoing management of these conditions.

Vital Trends

NULL (No vital signs data provided in the input data.)

Lab Trends

The following lab values were recorded at 64 minutes post-unit admission:

* Sodium: 140 mEq/L * Creatinine: 1.0 mg/dL * BUN: 22 mg/dL * Total Bilirubin: 0.4 mg/dL * WBC: 6.8 K/mcL * Glucose: 128 mg/dL * Hematocrit (Hct): 37.8 % * Albumin: 3.7 g/dL

These results provide a snapshot of the patient's biochemical and hematologic status at one point in time. Further data points would be needed to assess trends in these values.

Microbiology Tests

NULL (No microbiology test data provided in the input data.)

Physical Examination Results

The physical exam was performed. A Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) was recorded at 5 minutes post-unit admission. Respiratory mode was spontaneous.

The GCS score indicates normal neurological function at the time of the exam. The spontaneous respiratory mode suggests no immediate need for mechanical ventilation. More extensive physical exam findings are needed for a comprehensive assessment.