Medical Report for Patient 004-11678

1. Patient Information:

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

2. History:

The patient was admitted to the hospital via the Emergency Department with a primary diagnosis of Asthma. Additional significant diagnoses included Multiple Sclerosis (Major diagnosis), Acute Respiratory Distress (Major diagnosis), and Diabetes Mellitus (Major diagnosis) . The patient's medical history is not fully detailed in the provided data, preventing a more comprehensive narrative of the patient's condition prior to ICU admission.

3. Diagnoses:

The patient presented with multiple diagnoses during her stay. The primary diagnosis upon unit admission and discharge was Asthma (ICD-9 codes: 493.90, J45). Significant secondary diagnoses included Multiple Sclerosis (ICD-9 codes: 340, G35), Acute Respiratory Distress (ICD-9 code: 518.82), and Diabetes Mellitus. Hypertension (ICD-9 codes: 401.9, I10) was also noted as a secondary diagnosis.

4. Treatments:

The patient received a variety of treatments during her stay in the ICU. These included oxygen therapy via nasal cannula, bronchodilators, antiemetics (ondansetron), sedative agents (diazepam), VTE prophylaxis with compression boots, anticoagulant administration (coumadin), losartan (ARB), and nifedipine (vasodilator). A Foley catheter was also placed. Oral feeds were administered and physical therapy was consulted. Several of these treatments were active upon discharge from the unit, indicating ongoing management of the patient's conditions.

5. Vital Trends: NULL. No vital sign data was provided.

6. Lab Trends:

The following lab results were obtained at approximately 64 minutes post-unit admission:

* **Sodium:** 140 mEq/L * **Creatinine:** 1.0 mg/dL * **BUN:** 22 mg/dL * **Total Bilirubin:** 0.4 mg/dL * **Glucose:** 128 mg/dL * **WBC x 1000:** 6.8 K/mcL * **Hematocrit (Hct):** 37.8 % * **Albumin:** 3.7 g/dL

Further lab data is required to establish trends and evaluate the patient's response to treatment.

7. Microbiology Tests: NULL. No microbiology data was provided.

8. Physical Examination Results:

A structured physical exam was performed at approximately 5 minutes post-unit admission. The Glasgow Coma Scale (GCS) was documented as 15 (Eyes: 4, Verbal: 5, Motor: 6). Respiratory mode was spontaneous. Further details of the physical examination are not available in the provided data.