

## **\*\*Medical Report: Patient 002-1015\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 202707 \* \*\*Patient Health System Stay ID:\*\* 176710 \* \*\*Unique Patient ID:\*\* 002-1015 \*  
\*\*Gender:\*\* Female \* \*\*Age:\*\* 78 years \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 73 \* \*\*Ward ID:\*\* 100 \* \*\*Unit Type:\*\*  
Neuro ICU \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Admit Time:\*\* 04:22:00 (24-hour format) \* \*\*Unit  
Discharge Time:\*\* 04:05:00 (24-hour format) \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \*  
\*\*Hospital Admit Source:\*\* Direct Admit \* \*\*Hospital Admit Time:\*\* 04:22:00 (24-hour format) \* \*\*Hospital Discharge  
Time:\*\* 23:25:00 (24-hour format) \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \*  
\*\*Admission Weight:\*\* 50.6 kg \* \*\*Discharge Weight:\*\* 67.6 kg \* \*\*Admission Height:\*\* 157.5 cm \* \*\*APACHE Admission  
Dx:\*\* Head only trauma

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

NULL (Insufficient data provided)

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

The patient presented with multiple diagnoses, some active upon discharge and others resolved during the ICU stay. The diagnoses, listed in order of priority, were:

\* \*\*Primary Diagnoses:\*\* \* Intracranial injury with subdural hematoma (ICD-9 code: 852.20, S06.5) \* Intracranial injury with  
subarachnoid hemorrhage (ICD-9 code: 852.00, S06.6) \* Intracranial injury with intracerebral hemorrhage (ICD-9 code:  
851.80, S06.9) \* \*\*Major Diagnoses:\*\* \* Thrombocytopenia (ICD-9 code: 287.5, D69.6) \* Hypotension (ICD-9 code: 458.9,  
I95.9) \* Bradycardia \* \*\*Other Diagnoses:\*\* \* Diabetes Mellitus \* Hepatic dysfunction with cirrhosis (ICD-9 code: 571.5,  
K74.60)

Multiple entries for the same diagnosis indicate different instances of diagnosis during the patient's stay.

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

NULL (Insufficient data provided)

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

NULL (Insufficient data provided. Vital signs would typically be included in the dataset.)

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

The provided lab data includes multiple blood tests performed at various times during the patient's stay. These include complete blood counts (CBC) with differentials (-monos, WBC x 1000, -eos, RDW, platelets x 1000, MCV, -polys, -lymphs, Hgb, Hct, MCH, MCHC), basic metabolic panel (BMP) (glucose, potassium, calcium, chloride, BUN, anion gap, total protein, albumin, total bilirubin, AST (SGOT), ALT (SGPT)), and coagulation studies (PT, PTT, PT - INR). Specific trends cannot be determined without plotting the data over time.

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

NULL (Insufficient data provided)

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

A structured physical exam was performed. The Glasgow Coma Scale (GCS) was documented, with a total score of 15 (Eyes: 4, Verbal: 5, Motor: 6). Heart rate was recorded as 56 bpm (beats per minute). Blood pressure was recorded as 161/60 mmHg (millimeters of mercury). Oxygen saturation was 100%.