

****Medical Report for Patient 006-100175****

****1. Patient Information****

****Patient Unit Stay ID:**** 926319 ****Unique Patient ID:**** 006-100175 ****Gender:**** Female ****Age:**** 78 ****Ethnicity:**** Caucasian ****Hospital Admission Time:**** 2014, 23:43:00 ****Hospital Admission Source:**** Floor ****Hospital Discharge Year:**** 2014 ****Hospital Discharge Time:**** 01:58:00 ****Hospital Discharge Location:**** Other External ****Hospital Discharge Status:**** Alive ****Unit Type:**** Med-Surg ICU ****Unit Admission Time:**** 14:09:00 ****Unit Admission Source:**** Floor ****Unit Visit Number:**** 3 ****Unit Stay Type:**** Readmit ****Admission Height (cm):**** 162.5 ****Admission Weight (kg):**** 74.9 ****Discharge Weight (kg):**** NULL ****Unit Discharge Time:**** 18:41:00 ****Unit Discharge Location:**** Step-Down Unit (SDU) ****Unit Discharge Status:**** Alive ****Admission Diagnosis:**** Emphysema/bronchitis

****2. History****

NULL. The provided data does not contain a patient history. Further information is needed to complete this section. A comprehensive history would include details of presenting symptoms, duration of illness, relevant past medical history (including previous hospitalizations, surgeries, and chronic conditions), family history of relevant diseases, social history (e.g., smoking, alcohol use, occupation), and medication history.

****3. Diagnoses****

The patient presented with multiple diagnoses during her ICU stay. The following diagnoses were recorded:

****Primary Diagnosis (Active upon Discharge):**** Severe Sepsis (ICD-9 codes: 995.92, R65.2) ****Major Diagnosis (Active upon Discharge):**** COPD (ICD-9 codes: 491.20, J44.9) ****Major Diagnosis (Active upon Discharge):**** Acute Respiratory Failure (ICD-9 codes: 518.81, J96.00)

Additional diagnoses of COPD, Acute Respiratory Failure, and Severe Sepsis were also recorded but were not active upon discharge from the unit. The timing of these diagnoses relative to the admit time is indicated by the 'diagnosisoffset' field. Note that multiple entries for the same diagnosis exist, likely reflecting multiple assessments or updates to the diagnosis during the patient's stay.

****4. Treatments****

The patient received the following treatments during her ICU stay:

****Mechanical Ventilation:**** This treatment was administered, but was not active upon discharge. ****Non-invasive Ventilation:**** This treatment was administered, but was not active upon discharge. ****Fluid Bolus (Normal Saline):**** This treatment was administered, but was not active upon discharge.

The 'treatmentoffset' field indicates the time of initiation of each treatment. The absence of other treatment details limits the depth of this section. A more complete report would include details about dosages, routes of administration, response to treatment, and any complications encountered.

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

NULL. The provided data lacks time-series data on vital signs such as heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation. This information is crucial for assessing the patient's physiological status and response to treatment.

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

The patient underwent several laboratory tests during her ICU stay. The available data includes: Blood gas analyses (pH, PaO2, PaCO2, Base Excess, FiO2, O2 Sat), complete blood count (CBC) with differential (-polys, -bands, -lymphs, -monos, Hgb, Hct, MCV, MCH, MCHC, RDW, platelets), and chemistry tests (glucose, BUN, creatinine, sodium, chloride, potassium, bicarbonate, albumin, total protein, total bilirubin, ALT, AST, calcium, phosphate). Lactate and troponin levels were also measured. A detailed analysis of these trends requires time-series data, which is not fully available here. The provided data only shows individual lab results at various times, not a continuous trend. Many values are missing.

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

NULL. No microbiology test results are included in the provided data.

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

The physical exam documented a Glasgow Coma Scale (GCS) score of 10, with individual component scores of 3 (Eyes), 1 (Verbal), and 6 (Motor). Blood pressure was recorded as 166/87 mmHg (systolic/diastolic), and the admission weight was 74.9 kg. Intake was 0 ml, output 550 ml, resulting in a net fluid balance of -550 ml. The physical exam was performed and documented in a structured format. Further details are needed for a complete physical exam assessment.