Medical Report: Patient 006-107786

1. Patient Information:

* **Patient Unit Stay ID:** 788009 * **Unique Patient ID:** 006-107786 * **Gender:** Male * **Age:** 82 * **Ethnicity:** African American * **Hospital ID:** 175 * **Ward ID:** 417 * **Admission Height:** 163.8 cm * **Admission Weight:** 62.7 kg * **Discharge Weight:** 58.1 kg * **Hospital Admit Time:** 2015-XX-XX 02:17:00 (Hospital offset: -24007 minutes from unit admit) * **Hospital Admit Source:** Acute Care/Floor * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 21:32:00 (Hospital offset: 8828 minutes from unit admit) * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 18:24:00 * **Unit Admit Source:** ICU * **Unit Visit Number:** 2 * **Unit Stay Type:** stepdown/other * **Unit Discharge Time:** 2015-XX-XX 00:17:00 (Unit offset: 3233 minutes from unit admit) * **Unit Discharge Location:** Acute Care/Floor * **Unit Discharge Status:** Alive * **Admission Diagnosis (APACHE):** NULL

2. History:

Insufficient data provided to generate a detailed patient history. The available data only includes demographics and admission/discharge times for both the hospital and ICU stay. Further information is needed regarding presenting complaints, past medical history, family history, social history, and medication history to construct a comprehensive history section. The lack of an Admission Diagnosis (APACHE) field being populated also limits our understanding of the reason for admission.

3. Diagnoses:

NULL. No diagnoses are explicitly listed in the provided data. A complete diagnosis list would require access to the patient's medical records, including physician notes and discharge summaries.

4. Treatments:

NULL. The provided data does not contain information on any specific treatments administered during the patient's ICU stay. This section would require access to medication administration records, procedure notes, and other relevant clinical documentation.

5. Vital Trends:

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is included in the provided dataset. To generate vital trends, this data would be necessary.

6. Lab Trends:

The provided lab data shows multiple blood tests conducted at various times during the patient's stay. Key observations include:

* **Electrolytes:** Potassium levels fluctuated between 3.5 mmol/L and 4.2 mmol/L, with some higher values initially. Sodium levels remained relatively stable around 138-141 mmol/L. Chloride levels were consistently high (102-105 mmol/L). Bicarbonate levels were relatively stable around 25-27 mmol/L. Anion gap showed some fluctuation between 8 and 11. Calcium levels showed an upward trend, starting at 7.9 mg/dL and ending at 8.5 mg/dL. * **Renal Function:** BUN levels varied between 9 and 11 mg/dL, and creatinine levels ranged from 1.0 to 1.2 mg/dL, indicating some degree of renal impairment. * **Blood Glucose:** Glucose levels fluctuated between 78 and 95 mg/dL. * **Hematological parameters:** Hemoglobin (Hgb) levels were between 10.3 g/dL and 11 g/dL, suggesting anemia. Hematocrit (Hct) levels were between 30.9% and 33.5%, consistent with the anemia. Mean corpuscular volume (MCV) and mean corpuscular hemoglobin concentration (MCHC) suggest a normocytic, normochromic anemia. Mean Corpuscular Hemoglobin (MCH) and Mean Platelet Volume (MPV) and Platelet counts were within normal ranges. Red blood cell distribution width (RDW) was slightly

elevated (15.2%-15.4%), indicating some variation in red blood cell size.

More detailed analysis would require plotting these values against time to better understand trends and potential correlations with clinical events.

7. Microbiology Tests:

NULL. No microbiology data (e.g., cultures, sensitivities) is present in the given data.

8. Physical Examination Results:

NULL. The provided data set lacks any physical examination findings.