Medical Report - Patient 004-1044

1. Patient Information

* **Patient Unit Stay ID:** 326308 * **Unique Patient ID:** 004-1044 * **Gender:** Female * **Age:** 75 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 19:22:00 * **Hospital Discharge Time:** 2015-XX-XX 00:30:00 * **Unit Admit Time:** 2015-XX-XX 00:20:00 * **Unit Discharge Time:** 2015-XX-XX 00:30:00 * **Admission Weight:** 61.7 kg * **Admission Height:** 165.1 cm * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Location:** Other Hospital * **Unit Admit Source:** Emergency Department * **Unit Discharge Location:** Other Hospital * **Unit Type:** Med-Surg ICU

2. History

Insufficient data provided to generate a detailed patient history. The report only contains admission and discharge information, diagnoses, treatments, and some lab results. A complete history would require additional information such as presenting complaints, social history, family history, and past medical history. The admission diagnosis lists 'Rhythm disturbance (atrial, supraventricular)', suggesting a cardiac event precipitated the admission.

3. Diagnoses

* **Primary Diagnosis:** Atrial fibrillation (427.31, I48.0) - Active upon discharge. * **Major Diagnoses:** COPD (491.20, J44.9) - Not active upon discharge. The COPD diagnosis was listed both as active upon admission and inactive upon discharge, suggesting treatment was effective or the initial presentation was not considered the primary reason for hospitalization.

The presence of both cardiac and pulmonary diagnoses suggests a complex clinical picture requiring careful management. Further details on the severity and progression of each condition are needed for a complete assessment.

4. Treatments

The patient received the following treatments during their ICU stay:

* **Low molecular weight heparin:** For VTE prophylaxis (Venous Thromboembolism). Active upon discharge. * **Ondansetron:** Antiemetic (used to prevent nausea and vomiting). Not active upon discharge. * **Diltiazem:** A class IV antiarrhythmic medication used to treat atrial fibrillation. Active upon discharge. * **Pantoprazole:** Stress ulcer prophylaxis. Active upon discharge. * **Bronchodilator:** For pulmonary symptoms. Active upon discharge.

The choice of treatments reflects the patient’s diagnoses. The continued use of anticoagulation and antiarrhythmic medication upon discharge suggests ongoing management requirements.

5. Vital Trends

* **Heart Rate (HR):** Current HR 96 bpm, Lowest HR 96 bpm, Highest HR 97 bpm. * **Blood Pressure (BP):** Systolic BP (Current: 123 mmHg, Lowest: 120 mmHg, Highest: 143 mmHg); Diastolic BP (Current: 74 mmHg, Lowest: 77 mmHg, Highest: 84 mmHg). * **Respiratory Rate (RR):** Current RR 19 breaths/min, Lowest RR 19 breaths/min, Highest RR 24 breaths/min. * **Oxygen Saturation (O2 Sat):** Current O2 Sat 92%, Lowest O2 Sat 92%, Highest O2 Sat 92%.

The vital signs are largely unremarkable, with HR, BP, and RR within normal ranges for a 75-year-old female. The O2 saturation suggests adequate oxygenation at the time of measurement.

6. Lab Trends

The following lab values were recorded:

* **Sodium:** 144 mEq/L * **Glucose:** 101 mg/dL * **Albumin:** 3.4 g/dL * **Creatinine:** 0.7 mg/dL * **WBC x 1000:** 6.4 K/mcL * **Total Bilirubin:** 0.4 mg/dL * **FiO2:** 21% * **Hct:** 38.6% * **BUN:** 15 mg/dL

Interpretation of these lab values requires comparison to reference ranges and consideration of the clinical context. Without this additional data, a definitive assessment of these values cannot be made. Serial lab measurements are needed to assess trends and response to treatment.

7. Microbiology Tests

NULL. No microbiology test data was provided.

8. Physical Examination Results

The physical examination recorded a Glasgow Coma Scale (GCS) score of 14 (Eyes: 4, Verbal: 4, Motor: 6), indicating normal neurological function. The patient's weight was recorded at admission as 61.7 kg. Additional physical exam findings are not available in the provided dataset.