

****Patient Information****

Patient Unit Stay ID: 341064 Unique Patient ID: 004-10156 Gender: Female Age: 53 Ethnicity: Caucasian Hospital Admit Time: 2014-XX-XX 17:09:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2014-XX-XX 22:28:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 2014-XX-XX 21:23:00 Unit Admit Source: Emergency Department Unit Discharge Time: 2014-XX-XX 15:43:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Height (cm): 160 Admission Weight (kg): 77.11 Discharge Weight (kg): NULL

****Medical History****

Insufficient information provided to generate a detailed medical history. The provided data only includes diagnoses and treatments, not a narrative history of the patient's condition leading up to the ICU admission. Further information, such as previous medical records, family history, and social history, is required to complete this section.

****Diagnoses****

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnoses upon discharge were:

* Gastrointestinal, Abdominal/General, Abdominal pain/tenderness, Right upper quadrant (ICD-9: 789.01, R10.11) *
Gastrointestinal, Abdominal/General, Abdominal pain/tenderness, With guarding (ICD-9: 789.00, R10.9)

Other diagnoses included (not active upon discharge):

* Gastrointestinal, Hepatic disease, Hepatic dysfunction, Acute (ICD-9: 573.9, K76.9)

The temporal relationship between diagnoses is unclear, as the diagnosisOffset values represent the time since unit admission, not the onset of the condition. The diagnoses appear to be related to gastrointestinal issues.

****Treatments****

The patient received various treatments during her ICU stay. Active treatments upon discharge included:

* Infectious diseases, Cultures/immuno-assays, Cultures * Gastrointestinal, Intravenous fluid administration, Normal saline administration * Cardiovascular, Vascular disorders, VTE prophylaxis, Compression stockings * Gastrointestinal, Radiology, diagnostic and procedures, MRI, Pelvis * Gastrointestinal, Medications, Analgesics, Narcotic analgesic * Gastrointestinal, Medications, Analgesics, Bolus parenteral analgesics * Gastrointestinal, Consultations, Gastroenterology consultation * Gastrointestinal, Medications, Stress ulcer prophylaxis, Pantoprazole * Infectious diseases, Medications, Therapeutic antibacterials, Penicillins, Piperacillin/tazobactam * Neurologic, Pain/agitation/altered mentation, Sedative agent, Lorazepam

Inactive treatments upon discharge are also listed in the data and included a variety of consultations, medications, and radiology procedures. The exact scheduling and sequence of treatments are not detailed.

****Vital Trends****

NULL. No vital sign data is provided.

****Lab Trends****

The provided lab data shows multiple blood tests performed at different time points during the patient's stay. There are values for Hemoglobin (Hgb), Hematocrit (Hct), Red Blood Cell count (RBC), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), Red cell distribution width (RDW), White Blood Cell count (WBC), Platelets, total bilirubin, direct bilirubin, total protein, albumin, alkaline phosphatase, AST (SGOT), ALT (SGPT), BUN, creatinine, glucose, sodium, chloride, lipase, FiO2, Respiratory Rate, and LPM O2. The data requires further analysis to determine trends. There are multiple sets of results, suggesting repeat testing at different time points. It is important to note that some lab results are missing, denoted by empty strings. Further information is needed to interpret these results in the context of the patient's clinical course.

****Microbiology Tests****

The patient had cultures performed as part of her treatment for infectious diseases. Results are not provided.

****Physical Examination Results****

The physical exam documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6), heart rate ranging from 95 to 103 bpm, a respiratory rate of 19-23 breaths per minute, blood pressure (systolic) ranging from 136 to 151 mmHg, and blood pressure (diastolic) ranging from 64 to 88 mmHg. The patient's admission weight was 77.11 kg, and her respiratory mode was spontaneous. No other physical examination findings are documented.