Patient Medical Report

1. Patient Information:

* **Patient Unit Stay ID:** 417265 * **Patient Health System Stay ID:** 356060 * **Gender:** Female * **Age:** 42 * **Ethnicity:** NULL * **Hospital ID:** 120 * **Ward ID:** 248 * **Admission Diagnosis:** Sepsis, renal/UTI (including bladder) * **Hospital Admit Time:** 2014-XX-XX 17:50:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 23:22:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 06:01:00 * **Unit Admit Source:** Floor * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Unit Discharge Time:** 2014-XX-XX 17:53:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-13151

2. History:

NULL (Insufficient information provided)

3. Diagnoses:

The patient presented with multiple diagnoses upon admission to the Med-Surg ICU. These include:

* **Primary Diagnosis:** Sepsis (ICD-9 Codes: 038.9, A41.9) * **Major Diagnoses:** * Hyperglycemia (ICD-9 Codes: 790.6, R73.9) * Depression (ICD-9 Codes: 311, F32.9) * Hypotension (ICD-9 Codes: 458.9, I95.9) * Anxiety (ICD-9 Codes: 300.00, F41.9) * Hypovolemia (ICD-9 Codes: 276.52, E86.1) * Pain * Internal Hemorrhage (ICD-9 Codes: 998.11, I97.89)

All diagnoses were active upon discharge from the unit.

4. Treatments:

The patient received a comprehensive range of treatments during their ICU stay. These include:

* **Ureteral stenting** * **Sliding scale insulin administration** * **PCA analgesics** * **Lactated Ringer's administration** * **Oral feeds** * **Nasal cannula oxygen therapy (<40%)** * **Bolus parenteral analgesics** * **Chest x-ray** * **Compression stockings** * **Compression boots** * **Transfusion of >2 units PRBCs** * **Vancomycin** * **Piperacillin/tazobactam** * **Subcutaneous dose of regular insulin** * **Narcotic analgesic** * **Foley catheter**

All treatments were active upon discharge from the unit.

5. Vital Trends:

* **Heart Rate (HR):** Current HR 90, Lowest HR 88, Highest HR 90 * **Blood Pressure (BP):** Systolic BP: Current 107, Lowest 96, Highest 107; Diastolic BP: Current 72, Lowest 65, Highest 72 * **Respiratory Rate (RR):** Current RR 18, Lowest RR 15, Highest RR 18 * **Oxygen Saturation (O2 Sat):** Current O2 Sat 100%, Lowest O2 Sat 99%, Highest O2 Sat 100% * **Glasgow Coma Scale (GCS):** Total Score Scored, Motor Score 6, Verbal Score 5, Eyes Score 4

6. Lab Trends:

Only one lab result is available: FiO2 of 28% at 316 minutes post-admission. Additional data is needed for trend analysis.

7. Microbiology Tests:

NULL (Insufficient information provided)

8. Physical Examination Results:

A structured physical exam was performed. Vital signs (HR, BP, RR, O2 Sat) were recorded at 316 minutes post-admission. A GCS assessment was also performed, indicating a scored result. Further details on the physical examination are unavailable.

Note: This report is based solely on the provided data. The absence of certain information limits the comprehensiveness of this report. Additional data, including a complete history, detailed lab results, microbiology reports, and a more comprehensive physical examination, would greatly enhance the clinical picture.