Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 447543 * **Unique Patient ID:** 005-10606 * **Gender:** Male * **Age:** 80 * **Ethnicity:** Hispanic * **Hospital Admit Time:** 2015-XX-XX 10:12:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 06:45:00 * **Hospital Discharge Status:** Expired * **Hospital Discharge Location:** Death * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 11:06:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 21:00:00 * **Unit Discharge Status:** Alive * **Unit Discharge Location:** Floor * **Admission Weight:** 61.2 kg * **Admission Height:** 167.6 cm

2. Medical History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, all marked as Major except for the primary diagnosis:

* **Primary Diagnosis:** Sepsis with multi-organ dysfunction (ICD-9 codes: 995.92, R65.20) * **Major Diagnoses:** * Congestive heart failure (ICD-9 codes: 428.0, I50.9) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Hypochloremia (ICD-9 codes: 276.9, E87.8) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Acute pulmonary edema (ICD-9 codes: 428.1, I50.1) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Colitis, presumed infectious (ICD-9 codes: 009.1, A09) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Acute renal failure (ICD-9 codes: 584.9, N17.9) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Hypercoagulable state (ICD-9 codes: 286.9, D68.69) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Acute respiratory failure (ICD-9 codes: 518.81, J96.00) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Acute respiratory distress (ICD-9 code: 518.82) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Hyponatremia (ICD-9 codes: 276.1, E87.0, E87.1) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Malignant hyperthermia (ICD-9 codes: 359.89, G72.89) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Hypoxemia (ICD-9 codes: 799.02, J96.91) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission. * Change in mental status (ICD-9 codes: 780.09, R41.82) – recorded at 257 and 5581 minutes post-unit admission, and again at 7959 minutes post-unit admission.

Note that multiple entries for some diagnoses exist, possibly reflecting re-evaluations or updates during the patient's stay. The ICD-9 codes are provided for each diagnosis.

4. Treatments

The patient received a wide range of treatments during their ICU stay. These included consultations with Cardiology, Infectious Disease, Neurology, and Nephrology. Specific treatments included oxygen therapy (40%-60%), mechanical ventilation, various medications (aspirin, acetaminophen, piperacillin/tazobactam, metronidazole, levofloxacin, vancomycin, cefepime, pantoprazole), and diagnostic imaging (chest x-ray, CT scan, pulmonary ventilation perfusion study). The patient also had a Foley catheter placed. Finally, non-invasive testing was performed for DVT. Many of these treatments appear to have been administered multiple times. More detailed information on dosage and administration times would be needed for a complete treatment record.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

NULL (Insufficient data provided; only individual lab results are given, not trends over time)

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

The physical examination was performed, the structured results include the following:

* **Heart Rate (Current):** 66 bpm * **Heart Rate (Lowest):** 66 bpm * **Heart Rate (Highest):** 85 bpm * **Systolic Blood Pressure (Current):** 67 mmHg * **Systolic Blood Pressure (Lowest):** 62 mmHg * **Systolic Blood Pressure (Highest):** 152 mmHg * **Diastolic Blood Pressure (Current):** 48 mmHg * **Diastolic Blood Pressure (Lowest):** 42 mmHg * **Diastolic Blood Pressure (Highest):** 112 mmHg * **Respiratory Rate (Current):** 30 breaths/min * **Respiratory Rate (Lowest):** 28 breaths/min * **Respiratory Rate (Highest):** 34 breaths/min * **Oxygen Saturation (Current):** 79% * **Oxygen Saturation (Lowest):** 72% * **Oxygen Saturation (Highest):** 100% * **FiO2:** 50% * **PEEP:** 8 cm H2O * **Ventilation Rate (Current):** 20 breaths/min * **Admission Weight:** 61.2 kg * **Glasgow Coma Scale (GCS):** Unable to score due to medications

This report highlights the severity of the patient's condition, evident in the multiple major diagnoses and the range of treatments administered. Additional clinical data, such as vital signs over time and detailed lab results, are needed to complete a thorough analysis and provide more comprehensive trends. The lack of data concerning the patient's medical history also limits the report’s ability to provide a complete picture.