Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 405340 * **Patient Health System Stay ID:** 346335 * **Gender:** Male * **Age:** 58 * **Ethnicity:** Caucasian * **Hospital ID:** 133 * **Ward ID:** 176 * **Admission Height:** 180.3 cm (assuming cm) * **Admission Weight:** 71.7 kg * **Discharge Weight:** NULL * **Hospital Admit Time:** 2014-XX-XX 06:00:00 (Date missing from input) * **Hospital Discharge Time:** 2014-XX-XX 14:49:00 (Date missing from input) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 00:04:00 (Date missing from input) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 15:40:00 (Date missing from input) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-10577 * **APACHE Admission Diagnosis:** Pneumonia, bacterial

2. History

NULL (No history information provided in the input data.)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others resolved during the ICU stay. The primary diagnosis was community-acquired pneumonia (ICD-9: 486, J18.9). Major diagnoses included:

* **Altered mental status/pain:** This encompassed bipolar disorder (ICD-9: 296.80, F31.9) and depression (ICD-9: 311, F32.9). These diagnoses were active at discharge. * **Congestive heart failure:** (ICD-9: 428.0, I50.9), active at discharge. * **Acute COPD exacerbation:** (ICD-9: 491.21, J44.1), active at discharge.

Multiple entries for each diagnosis reflect the ongoing assessment and reassessment of the patient's condition.

4. Treatments

The patient received a comprehensive range of treatments, addressing various aspects of their condition. These included:

* **Respiratory Treatments:** Oxygen therapy (nasal cannula and 25-30%), bronchodilators (ipratropium, albuterol, nebulized treatments). Chest X-rays were performed multiple times. * **Antibiotics:** Levofloxacin (a quinolone antibiotic) was administered. * **Cardiovascular Management:** Diltiazem (a calcium channel blocker) was used to address potential arrhythmias. * **Gastrointestinal Management:** Pantoprazole (IV) was given for stress ulcer prophylaxis. * **Pain Management:** Ketorolac (a non-narcotic analgesic) and citalopram (an SSRI) were used to manage pain and altered mental status. * **VTE Prophylaxis:** Compression boots and stockings were utilized to prevent venous thromboembolism.

Several treatments were discontinued during the course of the patient's stay, while others continued until discharge.

5. Vital Trends

NULL (No vital signs data were provided.)

6. Lab Trends

The following lab values were recorded:

* **BUN:** 10 mg/dL * **Chloride:** 104 mmol/L * **Glucose:** 110 mg/dL * **Potassium:** 4.2 mmol/L * **Creatinine:** 0.9 mg/dL * **Sodium:** 139 mmol/L * **Albumin:** 2.8 g/dL * **WBC x 1000:** 13.2 K/mcL * **Hgb:** 13.0 g/dL * **Hct:** 40.4 % * **RDW:** 15 % * **Platelets x 1000:** 303 K/mcL * **FiO2:** 28 %

NULL (No trend analysis possible without time-series data)

7. Microbiology Tests

NULL (No microbiology data provided in the input.)

8. Physical Examination Results

The physical exam was performed and documented. The patient's weight at admission was 71.7 kg. A Glasgow Coma Scale (GCS) was recorded with eye, motor, and verbal scores of 4, 6, and 5 respectively, indicating a moderate level of impairment of consciousness.