

## **\*\*Medical Report for Patient 002-13199\*\***

### **\*\*1. Patient Information\*\***

\* \*\*Patient Unit Stay ID:\*\* 190446 \* \*\*Unique Patient ID:\*\* 002-13199 \* \*\*Patient Health System Stay ID:\*\* 167147 \*  
\*\*Gender:\*\* Female \* \*\*Age:\*\* 60 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 61 \* \*\*Ward ID:\*\* 120 \* \*\*Unit Type:\*\*  
Med-Surg ICU \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Admit Time:\*\* 01:30:00 \* \*\*Unit Discharge Time:\*\*  
16:53:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Source:\*\* Emergency  
Department \* \*\*Hospital Admit Time:\*\* 01:20:00 \* \*\*Hospital Discharge Time:\*\* 04:20:00 \* \*\*Hospital Discharge Location:\*\*  
Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Admission Height (cm):\*\* 162.6 \* \*\*Admission Weight (kg):\*\* 71.66 \*  
\*\*Discharge Weight (kg):\*\* 71.8 \* \*\*Admission Diagnosis:\*\* Sepsis, cutaneous/soft tissue

### **\*\*2. History\*\***

NULL (Insufficient information provided)

### **\*\*3. Diagnoses\*\***

\* \*\*Primary:\*\* Sepsis (ICD-9 codes: 038.9, A41.9) \* \*\*Major:\*\* Wound infection \* \*\*Other:\*\* Deep vein thrombosis (DVT)

The patient presented with sepsis as the primary diagnosis, accompanied by a major diagnosis of wound infection and an additional diagnosis of deep vein thrombosis. The timing of diagnosis entries suggests these conditions were identified relatively simultaneously upon admission to the ICU.

### **\*\*4. Treatments\*\***

NULL (Insufficient information provided)

### **\*\*5. Vital Trends\*\***

NULL (Insufficient information provided. While heart rate (HR), respiratory rate (Resp), and oxygen saturation (O2 Sat) are mentioned in the physical exam, time-series data is needed to show trends.)

### **\*\*6. Lab Trends\*\***

The provided lab data includes multiple time points for various blood tests, including complete blood count (CBC) differentials (-monos, MCH, -lymphs, MCHC, MCV, WBC x 1000, RBC, -bands, platelets x 1000, RDW, -polys, -eos, -basos), basic metabolic panel (BMP) components (glucose, calcium, total protein, bicarbonate, sodium, chloride, BUN, creatinine, anion gap, lactate), and coagulation studies (PT, PT-INR, ESR). However, the exact timing of these tests is not clearly defined in a consistent manner. This limits the ability to create a detailed trends analysis without additional data. The available data shows multiple measurements taken at approximately 570 minutes, 1450 minutes, 2020 minutes, 3500 minutes and 6960 minutes post-unit admission. A full analysis would require more specific timestamps for each individual lab result.

### **\*\*7. Microbiology Tests\*\***

NULL (Insufficient information provided)

### **\*\*8. Physical Examination Results\*\***

A structured physical exam was performed. The recorded vital signs at the time of initial exam (approximately 75 minutes post-unit admission) include:

\* \*\*Heart Rate (HR):\*\* Current: 105 bpm, Lowest: 105 bpm, Highest: 110 bpm \* \*\*Respiratory Rate (Resp):\*\* Current: 25 breaths/min, Lowest: 23 breaths/min, Highest: 25 breaths/min \* \*\*Oxygen Saturation (O2 Sat):\*\* Current: 96%, Lowest: 96%, Highest: 98% \* \*\*Weight (kg):\*\* Admission: 71.66 kg, Current: 71.8 kg, Delta: +0.14 kg \* \*\*Intake & Output (I&O):\*\* Intake Total: 0 ml, Output Total: 500 ml, Dialysis Net: 0 ml, Total Net: -500 ml \* \*\*Glasgow Coma Scale (GCS):\*\* Total Score: 15 (Eyes: 4, Verbal: 5, Motor: 6)

The relatively high respiratory rate and the negative fluid balance (-500ml) are notable findings that should be considered in the context of the patient's diagnoses.