Medical Report for Patient 007-10353

1. Patient Information

* **Patient Unit Stay ID:** 963941 * **Unique Patient ID:** 007-10353 * **Gender:** Female * **Age:** > 89 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 07:03:00 * **Hospital Discharge Time:** 2015-XX-XX 22:13:00 * **Unit Admission Time:** 2015-XX-XX 07:31:00 * **Unit Discharge Time:** 2015-XX-XX 14:29:00 * **Unit Type:** Med-Surg ICU * **Admission Weight (kg):** 69.5 * **Discharge Weight (kg):** 68.04 * **Hospital Admission Source:** NULL * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Admission Source:** Emergency Department * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Height (cm):** 154.9

2. History

The patient was admitted to the Med-Surg ICU from the Emergency Department with a primary diagnosis of CHF (Congestive Heart Failure). The exact circumstances leading to the ICU admission are not detailed in the provided data. Further information is needed to provide a complete history. The hospital admission source is missing from the provided data. The time between hospital admission and ICU admission was 28 minutes.

3. Diagnoses

* **Diagnosis ID:** 12780550 * **Patient Unit Stay ID:** 963941 * **Active Upon Discharge:** True * **Diagnosis Offset (minutes):** 34 * **Diagnosis String:** cardiovascular|ventricular disorders|congestive heart failure * **ICD-9 Code:** 428.0, I50.9 * **Diagnosis Priority:** Other

The primary diagnosis was congestive heart failure, indicated by both the admission diagnosis and the active diagnosis upon discharge. The ICD-9 codes suggest specific subtypes of heart failure, but the details of these are not provided in the supplied data. The diagnosis was recorded 34 minutes after unit admission.

4. Treatments

* **Treatment ID 27889721:** gastrointestinal|medications|stress ulcer prophylaxis (Active upon discharge) * **Treatment ID 27969529:** endocrine|glucose metabolism|insulin (Active upon discharge)

The patient received stress ulcer prophylaxis and insulin therapy during their ICU stay. Both treatments were active at the time of discharge. The specific medications used within these treatment categories are not specified.

5. Vital Trends

NULL. No vital sign trends are available in the provided data.

6. Lab Trends

The following laboratory results are available, although trends cannot be fully assessed without timestamps associated with each result:

* **Hematology:** Multiple hematology tests were performed, including complete blood count (CBC) with differential, and platelet count. Values available include 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, and differential counts (-monos, -lymphs, -eos, -basos, -polys). Some values were recorded at -92 minutes and others at 1627 minutes, indicating a possible before and after assessment. There is insufficient data to describe trends. * **Chemistry:** Blood glucose, BUN,

creatinine, electrolytes (sodium, potassium, chloride, bicarbonate), total bilirubin, direct bilirubin, albumin, total protein, ALT, AST, ionized calcium were measured. The values show some variation, but more data points are needed to establish trends. * **Cardiac Markers:** Troponin-I level is provided, showing a value of 0.03 ng/mL at 264 minutes, and 0.02 ng/mL at 664 minutes. This suggests a possible cardiac event, but more data is needed to confirm this. * **Other:** BNP values were recorded, suggesting evaluation for heart failure. The values are 2860 pg/mL at -92 minutes, and 2190 pg/mL at 1627 minutes. Further investigation of the values is needed.

7. Microbiology Tests

NULL. No microbiology test results are available in the provided data.

8. Physical Examination Results

A physical exam was performed. The Glasgow Coma Scale (GCS) was scored at 15 (Eyes: 4, Verbal: 5, Motor: 6). Heart rate (HR) ranged from 45 to 49 bpm. Systolic blood pressure (BP) ranged from 133 to 136 mmHg. Diastolic BP ranged from 68 to 100 mmHg. Respiratory rate (RR) ranged from 23 to 25 breaths per minute. Oxygen saturation (O2 Sat) ranged from 95 to 96%. Weight at admission was 69.5 kg and increased to 69.54 kg during the stay. Intake and output were recorded as 0 at the time of the exam.