Patient Information

Patient Unit Stay ID: 575545 Unique Patient ID: 006-100190 Gender: Female Age: 66 Ethnicity: Caucasian Hospital Admission Time: 2015, 19:55:00 Hospital Admission Source: Emergency Department Hospital Discharge Time: 2015, 02:05:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Neuro ICU Unit Admission Time: 2015, 20:07:00 Unit Admission Source: Emergency Department Unit Discharge Time: 2015, 02:05:00 Unit Discharge Location: Home Unit Discharge Status: Alive Admission Weight: 83.2 kg Admission Height: 168 cm

Medical History

Insufficient data provided to elaborate on the patient's detailed medical history beyond the information presented in the diagnoses section. A comprehensive history would include past medical conditions, surgeries, allergies, family history, and social history. This information is crucial for a complete medical picture but is missing from the provided dataset.

Diagnoses

Diagnosis 1 (Primary): Diagnosis String: neurologic|altered mental status / pain|obtundation ICD-9 Code: 780.09, R40.0 Active Upon Discharge: True Diagnosis Offset (minutes from unit admit): 13

Diagnosis 2 (Major): Diagnosis String: neurologic|altered mental status / pain|change in mental status ICD-9 Code: 780.09, R41.82 Active Upon Discharge: True Diagnosis Offset (minutes from unit admit): 13

The primary diagnosis indicates altered mental status and obtundation, while a secondary diagnosis points to a change in mental status. The ICD-9 codes suggest a need for further investigation into the underlying causes.

Treatments

NULL. No treatment information is available in the provided dataset. This section would typically detail medications administered, procedures performed, and other interventions undertaken during the patient's stay.

Vital Trends

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is included in the dataset. This information is essential for tracking the patient's physiological status over time.

Lab Trends

The following lab values were recorded:

Sodium: 143 mmol/L (initial), 143 mmol/L (follow-up) Bicarbonate: 22 mmol/L (initial), 24 mmol/L (follow-up) Calcium: 8.8 mg/dL (initial), 9.0 mg/dL (follow-up) Anion Gap: 13 (initial), 8 (follow-up) BUN: 2 mg/dL (initial), 3 mg/dL (follow-up) Potassium: 3.6 mmol/L (initial), 4.1 mmol/L (follow-up) Glucose: 111 mg/dL (initial), 138 mg/dL (follow-up) Hgb: 12.4 g/dL WBC x 1000: 5 K/mcL Creatinine: 0.46 mg/dL (initial), 0.46 mg/dL (follow-up) Chloride: 108 mmol/L (initial), 111 mmol/L (follow-up) HCO3 (ABG): 20.5 mmol/L paO2 (ABG): 71.7 mm Hg pH (ABG): 7.431 Base Excess (ABG): -2.4 mEq/L O2 Sat (%): 94.1 % Total Bilirubin: 0.6 mg/dL Albumin: 2.7 g/dL PT - INR: 1.1 ratio Platelets x 1000: 209 K/mcL MCV: 91 fL RBC: 4.13 M/mcL Lactate: 1.4 mmol/L Total Protein: 5.6 g/dL RDW: 13.6 % Bedside Glucose: 135 mg/dL, 155 mg/dL, 139 mg/dL ALT (SGPT): 30 Units/L Alkaline Phos.: 65 Units/L AST (SGOT): 33 Units/L PT: 13.9 sec MCH: 30 pg FiO2: 32 %

Note that some lab results show multiple entries. This may indicate measurements taken at different times during the patient's stay.

Microbiology Tests

NULL. No microbiology test results are provided in the dataset. This section would typically include information on cultures and sensitivities if performed.

Physical Examination Results

Physical Exam Performed: Yes Admission Weight: 83.2 kg GCS Score: 7 (Eyes: 1, Verbal: 1, Motor: 4)

The Glasgow Coma Scale (GCS) score of 7 indicates a severe level of impairment in consciousness. The low scores in both Eyes and Verbal components are particularly concerning.