Medical Report - Patient 005-10151

1. Patient Information

* **Patient Unit Stay ID:** 472811 * **Unique Patient ID:** 005-10151 * **Gender:** Male * **Age:** 64 * **Ethnicity:** Hispanic * **Hospital Admission Time:** 2014, 20:45:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014, 23:44:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Neuro ICU * **Unit Admission Time:** 04:14:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 18:31:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Height:** 175.3 cm * **Admission Weight:** 97.9 kg * **Discharge Weight:** NULL

2. History

Detailed patient history is not provided in the input data. This section would typically include information such as the reason for admission, presenting symptoms, past medical history (including surgeries, allergies, and significant illnesses), family history, social history (including smoking, alcohol, and drug use), and current medications. The absence of this information prevents a comprehensive history from being generated.

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These diagnoses, listed in order of priority and time of entry, are:

* **Primary Diagnosis:** * Cerebral subdural hematoma secondary to trauma (ICD-9 codes: 852.20, S06.5). This diagnosis was entered at 2590 minutes and 211 minutes post-unit admission. It was not active upon discharge. * **Major Diagnoses:** * Diabetes Mellitus. This diagnosis was entered at 3509 minutes, 2590 minutes, and 211 minutes post-unit admission. It was not active upon discharge. * Hyperglycemia (ICD-9 codes: 790.6, R73.9). This diagnosis was entered at 2590 minutes, 740 minutes, and 864 minutes post-unit admission. It was not active upon discharge. * Obesity (ICD-9 codes: 278.00, E66.9). This diagnosis was entered at 3509 minutes, 2590 minutes, and 369 minutes post-unit admission. It was not active upon discharge. * Acute Respiratory Distress (ICD-9 code: 518.82). This diagnosis was entered at 369 minutes post-unit admission. It was not active upon discharge. * **Other Diagnoses:** * Controlled Hypertension (ICD-9 codes: 401.9, I10). This diagnosis was entered at 2590 minutes and 3509 minutes post-unit admission. It was not active upon discharge.

4. Treatments

The following treatments were administered during the patient's ICU stay. Note that the 'active upon discharge' flag is false for all entries, indicating that none of these treatments were ongoing at the time of discharge from the unit.

* Gastrointestinal medications (stress ulcer prophylaxis with pantoprazole) were administered at 211 minutes and 2590 minutes post-unit admission. * Neurosurgery consultations were performed at 2590 minutes and 211 minutes post-unit admission. * Renal electrolyte correction/administration was performed at 211 minutes post-unit admission. * Endocrine glucose metabolism management (subcutaneous regular insulin) was administered at 740 minutes and 2590 minutes post-unit admission. * Cardiovascular management (nicardipine) was administered at 2590 minutes post-unit admission. * Pulmonary oxygen therapy via nasal cannula was administered at 2590 minutes post-unit admission. * Cardiovascular VTE prophylaxis with compression boots was administered at 211 minutes, 740 minutes, and 3509 minutes post-unit admission. * Neurological procedures/diagnostics (head CT scan) were performed at 740 minutes, 211 minutes, 2590 minutes, and 369 minutes post-unit admission. * Pulmonary consultations (Pulmonary/CCM consultation) were performed at 211 minutes, 2590 minutes, and 369 minutes post-unit admission. * Gastrointestinal radiology procedures (CT scan without IV contrast) were performed at 369 minutes and 740 minutes post-unit admission. * Endocrine glucose metabolism management (sliding scale insulin administration) was performed at 740 minutes and 369 minutes post-unit admission. * Cardiovascular intravenous fluid (normal saline) administration was administered at 211 minutes, 740 minutes, and 3509 minutes post-unit admission.

5. Vital Trends

Vital signs (Heart Rate, Blood Pressure, Respiratory Rate, and Oxygen Saturation) were recorded at multiple time points during the patient's stay. However, the provided data doesn't include the exact timing of each measurement. To analyze vital trends, a time-series representation of these vital signs is necessary. NULL

6. Lab Trends

Multiple laboratory tests were performed. Similar to vital signs, the precise timing of these tests is missing. To fully assess lab trends, a time-series analysis is required. The tests performed include: Base Excess, O2 Content, RBC, Hct, MCV, MCHC, Platelets, WBC, BUN, Glucose, Bicarbonate, Anion Gap, Calcium, Chloride, Magnesium, Troponin-I, ALT (SGPT), AST (SGOT), Total Bilirubin, Direct Bilirubin, Total Protein, Phosphate, PT, PTT, PT-INR, and bedside glucose. NULL

7. Microbiology Tests

Microbiology test results are not included in the provided data. NULL

8. Physical Examination Results

Several physical examinations were performed. These were performed at 8, 199, 738, 2101 and 3488 minutes post unit admission. The examinations revealed the patient to be ill-appearing but not in acute distress. Vital signs, neurological status (GCS 15, normal LOC, orientation x3, calm/appropriate affect, normal sensation and motor function), head and neck (non-icteric conjunctiva, normal ears, nose, and throat, normal neck mobility, JVD absent, non-tender neck), pulmonary (clear to auscultation, not intubated), cardiovascular (normal pulses, S1 and S2 normal), and gastrointestinal (normal bowel sounds, no pain on palpation) findings were documented. The patient's admission weight was recorded as 97.9 kg. Fluid balance was also tracked with varying intake and output values.