Medical Report for Patient 004-104

1. Patient Information

* **Patient Unit Stay ID:** 314161 * **Unique Patient ID:** 004-104 * **Gender:** Male * **Age:** 25 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 15:51:00 * **Hospital Discharge Time:** 2015-XX-XX 01:37:00 * **Unit Admission Time:** 2015-XX-XX 18:24:00 * **Unit Discharge Time:** 2015-XX-XX 01:30:00 * **Admission Weight:** 68.85 kg * **Discharge Weight:** NULL * **Admission Height:** 177.8 cm * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Admit Source:** Emergency Department * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Unit Type:** Med-Surg ICU

2. History

The patient was admitted to the hospital from the Emergency Department with a primary diagnosis of pneumonia and aspiration. The patient presented with altered mental status and pain, and a toxicology screen revealed a drug overdose. The exact nature of the drug overdose is not specified in the available data. The patient's history prior to admission is not detailed in the provided information.

3. Diagnoses

The patient received multiple diagnoses during their ICU stay. These included:

* **Primary:** * Pneumonia (507.0, J69.0) * Aspiration Pneumonia (507.0, J69.0) * **Major:** * Drug overdose - general * Change in mental status (780.09, R41.82) * Pulmonary aspiration (507.0, J69.0) * Respiratory failure (507.0, J69.0)

The diagnoses of drug overdose and respiratory failure were active upon discharge from the unit. The timing of diagnosis entry is indicated by the 'diagnosisoffset' field, suggesting some diagnoses were recorded relatively soon after admission, while others were noted later in the stay.

4. Treatments

The patient received a variety of treatments during their ICU stay. These included:

* **Respiratory Support:** Oxygen therapy via nasal cannula * **Antibiotics:** Piperacillin/tazobactam * **Gastrointestinal Medications:** Pantoprazole (stress ulcer prophylaxis) * **Sedation:** Lorazepam * **VTE Prophylaxis:** Compression boots * **Radiological Procedures:** Chest x-ray

Several treatments were active upon discharge from the unit, indicating ongoing management of the patient's conditions.

5. Vital Trends

NULL. No vital sign data are included in the provided JSON.

6. Lab Trends

The following lab results were obtained at 1371 minutes post-unit admission:

* **Hemoglobin (Hgb):** 14.6 g/dL * **White Blood Cell Count (WBC):** 12 K/mcL * **Mean Corpuscular Hemoglobin Concentration (MCHC):** 34 g/dL * **Platelets:** 305 K/mcL * **Red Cell Distribution Width (RDW):** 13.6 % * **Red Blood Cell Count (RBC):** 4.96 M/mcL * **Hematocrit (Hct):** 43.6 % * **Eosinophils:** 2 % * **Mean Corpuscular

Hemoglobin (MCH):** 30 pg * **Lymphocytes:** 12 % * **Monocytes:** 8 % * **Basophils:** 1 % * **Polymorphonuclear leukocytes:** 78 % * **Lactate (obtained at -26 minutes post-unit admission):** 1.2 mmol/L * **Mean Corpuscular Volume (MCV):** 88 fL

Additional lab result information is not provided.

7. Microbiology Tests

NULL. No microbiology test data are included in the provided JSON.

8. Physical Examination Results

A structured physical exam was performed. Initial vital signs included a heart rate of 113 bpm, systolic blood pressure of 103 mmHg, diastolic blood pressure of 73 mmHg, respiratory rate of 16 breaths per minute, and oxygen saturation of 98% on a FiO2 of 28%. A Glasgow Coma Scale (GCS) score of 15 (E4V5M6) was recorded.

--- **Word Count:** Approximately 600 words