

****Medical Report: Patient 004-12627****

****1. Patient Information****

* **Patient Unit Stay ID:** 310446 * **Unique Patient ID:** 004-12627 * **Gender:** Male * **Age:** 40 * **Ethnicity:** NULL * **Hospital Admit Time:** 2015-XX-XX 05:00:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 21:32:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 03:54:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 21:32:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Weight:** 101.5 kg * **Discharge Weight:** NULL * **Admission Height:** 198.1 cm

****2. History****

Admission diagnosis was Diabetic Ketoacidosis (DKA). The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU. Further details regarding the patient's medical history prior to admission are not available in the provided data.

****3. Diagnoses****

The patient's diagnoses upon discharge from the ICU included:

* **Primary:** Diabetic Ketoacidosis (DKA) (ICD-9: 250.13, E10.1) * **Major:** Type I Diabetes Mellitus (ICD-9: NULL) * **Major:** Hypertension (ICD-9: 401.9, I10) * **Major:** Bipolar Disorder (ICD-9: 296.80, F31.9) * **Major:** Depression (ICD-9: 311, F32.9) * **Major:** Pain (ICD-9: NULL) * **Other:** Nausea (ICD-9: 787.02, R11.0) * **Other:** Vomiting (ICD-9: 787.03, R11.10) * **Other:** Regurgitant Esophagitis (ICD-9: 530.11, K21.0)

All diagnoses were active upon discharge.

****4. Treatments****

The patient received the following treatments during their ICU stay:

* Oral Feeds * Promethazine (antiemetic) * Continuous Insulin Infusion * Sliding Scale Insulin Administration * Compression Stockings (VTE prophylaxis) * Narcotic Analgesics * Bolus Parenteral Analgesics * Potassium (electrolyte administration) * Intravenous Fluids (normal saline, both bolus and moderate volume resuscitation) * Central Venous Catheter Placement

All treatments were active upon discharge.

****5. Vital Trends****

NULL. No vital sign data was provided.

****6. Lab Trends****

The following lab results were recorded:

* **Initial Blood Gas (ABG):** pH 7.24, PaO2 150 mmHg, PaCO2 48 mmHg, FiO2 21% (obtained -160 minutes from unit admit time) * **Chemistry Panel:** Total Bilirubin 0.6 mg/dL, Sodium 138 mEq/L, Albumin 3.5 g/dL, BUN 23 mg/dL, Creatinine 1.0 mg/dL, Glucose 382 mg/dL (obtained -160 minutes from unit admit time) * **Hematology:** Hematocrit 41.8% (obtained -160 minutes from unit admit time), WBC 9.8 K/mcL (obtained -160 minutes from unit admit time)

Note: The exact timing of lab results relative to each other and to the patient's admission is not fully specified. Further longitudinal data would enable trend analysis.

****7. Microbiology Tests****

NULL. No microbiology test data was provided.

****8. Physical Examination Results****

Physical exam performed at 179 minutes post unit admission. The patient was noted as ill-appearing. Admission weight was recorded as 101.5 kg. Vital signs at the time of exam: Heart rate 86 bpm, systolic blood pressure 124 mmHg, diastolic blood pressure 70 mmHg, respiratory rate 18 breaths/min, regular sinus rhythm, spontaneous respirations. GCS score was 15/15 (Eyes 4, Verbal 5, Motor 6). Level of consciousness was normal.

****Note:**** This report is based solely on the provided data. Missing information may significantly impact the completeness and accuracy of this analysis. More extensive data would allow for a more detailed and comprehensive assessment of the patient's condition during their ICU stay. This report does not constitute medical advice.