

## **\*\*Medical Report: Patient 002-10865\*\***

### **\*\*1. Patient Information\*\***

\* \*\*Patient Unit Stay ID:\*\* 210641 \* \*\*Unique Patient ID:\*\* 002-10865 \* \*\*Gender:\*\* Female \* \*\*Age:\*\* 60 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 59 \* \*\*Ward ID:\*\* 91 \* \*\*Admission Diagnosis (APACHE):\*\* NULL \* \*\*Admission Height:\*\* 152.4 cm \* \*\*Hospital Admit Time:\*\* 2015-XX-XX 06:33:00 (Hospital Admit Offset: -81 minutes from Unit Admit Time) \* \*\*Hospital Admit Source:\*\* Emergency Department \* \*\*Hospital Discharge Year:\*\* 2015 \* \*\*Hospital Discharge Time:\*\* 2015-XX-XX 22:30:00 (Hospital Discharge Offset: 3756 minutes from Unit Admit Time) \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 2015-XX-XX 07:54:00 \* \*\*Unit Admit Source:\*\* ICU to SDU \* \*\*Unit Visit Number:\*\* 2 \* \*\*Unit Stay Type:\*\* stepdown/other \* \*\*Admission Weight:\*\* NULL \* \*\*Discharge Weight:\*\* 100.3 kg \* \*\*Unit Discharge Time:\*\* 2015-XX-XX 17:47:00 (Unit Discharge Offset: 2033 minutes from Unit Admit Time) \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive

### **\*\*2. History\*\***

Insufficient data provided to generate a detailed patient history. The available data only provides admission and discharge times and locations, along with some demographic information. A complete history would require additional information such as presenting complaints, past medical history, family history, social history, and medication history. Further details on the reason for admission to the ICU and the events leading to the ICU stay are needed.

### **\*\*3. Diagnoses\*\***

NULL. No diagnoses are explicitly listed in the provided data. The APACHE admission diagnosis field is empty.

### **\*\*4. Treatments\*\***

NULL. No treatment information is included in the provided dataset. A complete treatment section would detail all medications administered, procedures performed, and any other interventions.

### **\*\*5. Vital Trends\*\***

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation, etc.) is available to create vital sign trends.

### **\*\*6. Lab Trends\*\***

The following laboratory test results are available, but without timestamps beyond offsets from unit admission, creating detailed trends is impossible. Additional timestamps are needed to create meaningful visualizations of the lab trends. The provided data shows multiple lab tests performed at different times during the hospital stay. These include blood chemistry (glucose, BUN, creatinine, bicarbonate, sodium, potassium, chloride, anion gap), and hematology (Hgb, Hct, RBC, MCV, MCH, MCHC, RDW, platelets, WBC, differential counts). Many tests were repeated, suggesting monitoring of the patient's condition over time.

### **\*\*7. Microbiology Tests\*\***

NULL. There is no microbiology test data provided.

### **\*\*8. Physical Examination Results\*\***

NULL. No physical examination findings are provided in the data.

