Patient Information

Patient Unit Stay ID: 942382 Unique Patient ID: 006-108348 Gender: Female Age: > 89 Ethnicity: Caucasian Hospital Admit Time: 2014-01-01 13:51:00 (Hospital Admit Offset: -1532 minutes) Hospital Admit Source: Floor Hospital Discharge Year: 2014 Hospital Discharge Time: 2014-01-01 20:45:00 (Hospital Discharge Offset: 3202 minutes) Hospital Discharge Location: Skilled Nursing Facility Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 2014-01-01 15:23:00 Unit Admit Source: Floor Unit Visit Number: 1 Unit Stay Type: admit Admission Weight: 68.2 kg Discharge Weight: 68.8 kg Unit Discharge Time: 2014-01-01 18:52:00 (Unit Discharge Offset: 1649 minutes) Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Height: 153 cm APACHE Admission Dx: Rhythm disturbance (atrial, supraventricular)

Medical History

NULL (Insufficient data provided.)

Diagnoses

Diagnosis ID: 10481726 Patient Unit Stay ID: 942382 Active Upon Discharge: True Diagnosis Offset: 627 minutes Diagnosis String: cardiovascular|arrhythmias|atrial fibrillation|with rapid ventricular response ICD-9 Code: 427.31, I48.0 Diagnosis Priority: Primary

Diagnosis ID: 10488346 Patient Unit Stay ID: 942382 Active Upon Discharge: False Diagnosis Offset: 57 minutes Diagnosis String: cardiovascular|arrhythmias|atrial fibrillation|with rapid ventricular response ICD-9 Code: 427.31, I48.0 Diagnosis Priority: Primary

The patient presented with atrial fibrillation with rapid ventricular response, a primary diagnosis that remained active upon discharge. A second entry for the same diagnosis exists, but it was marked as inactive upon discharge. Further details regarding the patient's medical history are needed to provide a more comprehensive report.

Treatments

Treatment ID: 25033406 Patient Unit Stay ID: 942382 Treatment Offset: 57 minutes Treatment String: cardiovascular|arrhythmias|antiarrhythmics|class IV antiarrhythmic|diltiazem Active Upon Discharge: False

The patient received diltiazem, a Class IV antiarrhythmic, for the management of atrial fibrillation. This treatment was discontinued before discharge.

Vital Trends

NULL (Insufficient data provided. Vital signs would typically be included in a time series to show trends.)

Lab Trends

The provided lab data includes multiple time points for several key blood chemistry and hematology parameters. A detailed analysis requires time series visualization. Key observations from the available data include fluctuations in creatinine, potassium, and calcium levels. Anion gap also shows variation. Troponin I level is elevated (1.64 ng/mL) at the initial lab draw. Hemoglobin levels show a decrease from 12.3 g/dL to 11.2 g/dL, suggesting potential blood loss or anemia. Further interpretation requires a time-series analysis to understand the trends and their clinical significance.

Microbiology Tests

NULL (Insufficient data provided.)

Physical Examination Results

Physical Exam was performed and documented. The following vital signs were recorded: Heart Rate (Current): 93 bpm Heart Rate (Lowest): 93 bpm Heart Rate (Highest): 113 bpm Systolic Blood Pressure (Current): 90 mmHg Systolic Blood Pressure (Lowest): 90 mmHg Systolic Blood Pressure (Highest): 113 mmHg Diastolic Blood Pressure (Current): 55 mmHg Diastolic Blood Pressure (Lowest): 55 mmHg Diastolic Blood Pressure (Highest): 84 mmHg Respiratory Rate (Current): 17 breaths/min Respiratory Rate (Lowest): 17 breaths/min Respiratory Rate (Highest): 22 breaths/min Oxygen Saturation (Current): 98% Oxygen Saturation (Lowest): 97% Oxygen Saturation (Highest): 99% Weight (Admission): 68.2 kg Glasgow Coma Scale (GCS) Score: 15 (Eyes: 4, Verbal: 5, Motor: 6)

The physical examination findings show the patient's vital signs within a range indicating some degree of hemodynamic instability. A GCS of 15 suggests normal neurological function.