

## **\*\*Medical Report: Patient 003-11972\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 288133 \* \*\*Unique Patient ID:\*\* 003-11972 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 79 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital Admit Time:\*\* 2015, 19:00:00 \* \*\*Hospital Admit Source:\*\* Emergency Department \* \*\*Hospital Discharge Time:\*\* 2015, 18:45:00 \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 2015, 19:00:00 \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Discharge Time:\*\* 2015, 13:30:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Admission Weight:\*\* 82.7 kg \* \*\*Discharge Weight:\*\* 84.1 kg \* \*\*Admission Height:\*\* 170.2 cm

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

NULL (Insufficient information provided to generate a detailed patient history.)

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

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis, identified as 'burns/trauma|trauma - skeletal|bone fracture(s)|pelvis|closed' with ICD-9 code 808.8, was recorded as primary. Other diagnoses included:

\* \*\*Anemia:\*\* 'hematology|bleeding and red blood cell disorders|anemia' (active upon discharge) \* \*\*Hypocalcemia:\*\* 'renal|electrolyte imbalance|hypocalcemia' (active upon discharge) with ICD-9 codes 275.41, E83.51 \* \*\*Dementia:\*\* 'neurologic|altered mental status / pain|dementia' (active upon discharge) with ICD-9 codes 294.9, F03 \* \*\*Ventricular premature beats:\*\* 'cardiovascular|arrhythmias|ventricular premature beats' (active upon discharge) with ICD-9 codes 427.69, I49.3

Multiple entries for the same diagnosis (pelvic fracture) exist, indicating repeated documentation throughout the stay. The timing of these entries suggests ongoing monitoring and management of this condition.

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

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

\* \*\*Medications:\*\* Antiemetics (promethazine and ondansetron), stress ulcer prophylaxis (pantoprazole) \* \*\*Procedures:\*\* Head CT scan, spine CT scan \* \*\*Surgical Interventions:\*\* Internal fixation (multiple entries suggest this was an ongoing treatment) \* \*\*Electrolyte Administration:\*\* Potassium and Magnesium \* \*\*Intravenous Fluids:\*\* Normal saline

The treatments administered reflect a multi-system approach, addressing the patient's various diagnoses. The use of multiple entries for the same treatment further suggests a dynamic management plan.

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

NULL (Insufficient data to generate vital sign trends. While some vital signs are present in the physical exam section, they are isolated points and do not constitute a trend.)

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

The provided lab data shows multiple blood tests taken at different time points. Key lab results and their trends (where data allows) include:

\* \*\*Potassium:\*\* Initial potassium levels were 3.7 mmol/L, then increased to 4.1 mmol/L. This suggests potential electrolyte imbalance management. \* \*\*BUN (Blood Urea Nitrogen):\*\* BUN levels fluctuated between 19 mg/dL and 25 mg/dL, indicating potential fluctuations in renal function. \* \*\*Creatinine:\*\* Creatinine levels ranged from 1.0 mg/dL to 1.3 mg/dL, suggesting some variation in renal function. \* \*\*Hematological Parameters:\*\* Significant changes observed in Hemoglobin (Hgb), Hematocrit (Hct), MCV, MCH, MCHC, RDW, WBC, Platelets and differential counts across various time points. These indicate the patient's anemia and the body's response to the trauma. Further analysis is needed to understand the exact trends.

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

NULL (No microbiology test results were provided.)

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

Physical examinations were performed at multiple times. The initial and final examinations at 90 minutes and 3659 minutes from unit admission, respectively, showed:

\* \*\*Initial Exam:\*\* Heart rate (HR) between 60 and 67 bpm, with a sinus rhythm and PVCs. Blood pressure (BP) ranged from 109/56 to 130/73 mmHg. Respiratory rate (RR) was between 12 and 17 breaths per minute, with spontaneous respiration. Oxygen saturation (O2 Sat) was 99-100%. Weight was recorded at 77.1 kg. A GCS score of 13 was recorded (Eyes 4, Verbal 5, Motor 4). \* \*\*Final Exam:\*\* HR between 65 and 86 bpm, with sinus rhythm and PVCs. BP ranged from 96/37 to 140/74 mmHg. RR was between 5 and 21 breaths per minute, with spontaneous respiration. O2 Sat was 92-99%. Weight was 82.7 kg (admission weight) and 82.7 kg (current weight) suggesting no significant weight change during the stay. A GCS score was recorded as 'scored'.

The physical exam findings reflect a patient with cardiovascular irregularities, respiratory variability, and a neurological status requiring monitoring. The lack of detailed descriptions for many entries limits the full interpretation.