Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 399713 * **Patient Health System Stay ID:** 341753 * **Gender:** Female * **Age:** 75 * **Ethnicity:** Caucasian * **Hospital ID:** 133 * **Ward ID:** 176 * **Admission Height (cm):** 152.4 * **Admission Weight (kg):** 64.8 * **Hospital Admit Time:** 2015-XX-XX 19:47:00 (Hospital offset: -88 minutes from unit admit) * **Hospital Admit Source:** NULL * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 18:10:00 (Hospital offset: 7015 minutes from unit admit) * **Hospital Discharge Location:** Nursing Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 21:15:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Unit Discharge Time:** 2015-XX-XX 20:45:00 (Unit offset: 5730 minutes from unit admit) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-1044 * **Admission Diagnosis:** Restrictive lung disease (i.e., Sarcoidosis, pulmonary fibrosis)

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis was congestive heart failure (ICD-9 codes: 428.0, I50.9), which was active upon discharge. Major diagnoses included acute COPD exacerbation (ICD-9 codes: 491.21, J44.1) and atrial fibrillation (ICD-9 codes: 427.31, I48.0). Both acute COPD exacerbation and atrial fibrillation were initially diagnosed early in the stay but were not active upon discharge. It's important to note that the diagnosis of congestive heart failure was entered later into the patient's stay (1204 minutes after unit admission). The multiple entries for each diagnosis suggest either revisions or additional documentation made at different times during the stay. This may warrant further investigation into the clinical course of the patient's conditions.

4. Treatments

The patient received a variety of treatments during her ICU stay. Treatments for congestive heart failure included intravenous furosemide (IV furosemide). The patient also received treatment for acute COPD exacerbation including azithromycin, albuterol (Proventil, Ventolin), ipratropium, and acetaminophen. Metoprolol was administered for hypertension. Ondansetron was used as an antiemetic, and enoxaparin was used for VTE prophylaxis. Oxygen therapy via nasal cannula was administered. Note that several treatments were active upon discharge, suggesting ongoing management of these conditions. The timing of treatment initiation (offsets from unit admit time) provides valuable information about the progression of the patient's condition and the response to interventions.

5. Vital Trends

* **Heart Rate (HR):** 112 bpm (at 37 minutes post-admission). Further data is needed to determine trends. * **Blood Pressure (BP):** 131/71 mmHg (at 37 minutes post-admission). Further data is needed to determine trends. * **Respiratory Rate:** 23 breaths/minute (at 37 minutes post-admission). Further data is needed to determine trends. * **Oxygen Saturation (SpO2):** 98% (at 37 minutes post-admission). Further data is needed to determine trends. * **FiO2:** 22% (at 37 minutes post-admission). Further data is needed to determine trends. * **Respiratory Mode:** spontaneous (at 37 minutes post-admission). Further data is needed to determine trends. * **Glasgow Coma Scale (GCS):** 14 (Eyes: 4, Verbal: 4, Motor: 6 - at 37 minutes post-admission). Further data is needed to determine trends.

6. Lab Trends

Initial laboratory results (drawn 185 minutes before unit admission) revealed: * **Creatinine:** 1.0 mg/dL * **BUN:** 27 mg/dL * **Sodium:** 143 mEq/L * **Potassium:** 4.1 mEq/L * **Glucose:** 191 mg/dL * **Total Bilirubin:** 0.3 mg/dL * **Hemoglobin (Hgb):** 12.4 g/dL * **Hematocrit (Hct):** 41.5 % * **White Blood Cell Count (WBC):** 13.7 K/mcL

A later arterial blood gas (ABG) analysis (35 minutes post-admission) showed: * **FiO2:** 22% * **O2 Saturation:** 95%

Further data is needed to assess trends over time.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

Physical examination at 37 minutes post-admission revealed a GCS score of 14, with an admission weight of 64.8 kg. Vital signs recorded at the same time included a HR of 112 bpm, BP of 131/71 mmHg, respiratory rate of 23 breaths/minute, SpO2 of 98%, and FiO2 of 22% with spontaneous respiration.