Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 350259 * **Unique Patient ID:** 004-11402 * **Gender:** Male * **Age:** 88 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 16:17:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 01:15:00 * **Hospital Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 20:15:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 17:59:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 67.5 kg * **Admission Height:** 162.5 cm

2. History

NULL. The provided data does not contain a patient history. A comprehensive medical history would include details of presenting complaints, past medical history, family history, social history, and medication history. This information is crucial for a complete understanding of the patient's condition.

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was Congestive Heart Failure (CHF) (ICD-9 codes: 428.0, I50.9). Other significant diagnoses included:

* **Altered Mental Status/Depression:** (ICD-9 codes: 311, F32.9) – Active upon discharge. * **Chest Pain/ASHD:** (ICD-9 codes: 786.50, R07.9) – Active upon discharge. * **Suicidal Ideation:** (ICD-9 codes: V62.84, R45.851) – Active upon discharge. * **Abdominal Pain/Tenderness:** (ICD-9 codes: 789.00, R10.9) – Active upon discharge.

Note: Some diagnoses were present during admission but were not active at the time of discharge, indicating potential resolution or improvement during treatment.

4. Treatments

The patient received various treatments during their ICU stay, including:

* **Cardiovascular Treatments:** Anticoagulant administration (Enoxaparin), analgesics (bolus parenteral and narcotic), antiplatelet agent (aspirin), nitroglycerin (sublingual), and IV furosemide. * **Gastrointestinal Treatments:** Stress ulcer prophylaxis (pantoprazole) and oral feeds. * **Pulmonary Treatments:** Oxygen therapy (25-30% and nasal cannula). * **Psychiatric Consultation:** Suicide precautions were initiated and maintained.

The active treatments upon discharge highlight the ongoing management of CHF, pain, and mental health conditions.

5. Vital Trends

* **Heart Rate (HR):** The recorded HR ranged from 112 to 124 bpm, with a current HR of 121 bpm at the time of physical examination. * **Respiratory Rate (RR):** The RR ranged from 22 to 33 breaths per minute, with a current RR of 23 breaths per minute at the time of the physical examination. * **Blood Pressure (BP):** Systolic BP was recorded at 117 mmHg, and diastolic BP at 74 mmHg. Additional BP readings are needed to establish trends. * **Oxygen Saturation (SpO2):** SpO2 ranged from 94% to 97%, with a current saturation of 96% at the time of physical examination.

6. Lab Trends

The following lab results are available:

* **Troponin-I:** 0.37 ng/mL * **CPK-MB Index:** 3% * **CPK-MB:** 3 ng/mL * **Glucose:** 176 mg/dL * **WBC:** 82.2 K/mcL * **BUN:** 47 mg/dL

More frequent lab data points are needed to establish trends and assess the progression of the patient's condition. The available data represents a single point in time.

7. Microbiology Tests

NULL. The provided data does not include microbiology test results.

8. Physical Examination Results

The physical examination revealed:

* **Glasgow Coma Scale (GCS):** 15 (Eyes 4, Verbal 5, Motor 6) * **Weight:** 67.5 kg

The physical exam findings suggest the patient's neurological status was relatively normal. The other vital sign data are listed above in Vital Trends.