Patient Information

Patient Unit Stay ID: 389791 Unique Patient ID: 004-11795 Gender: Female Age: 48 Ethnicity: Caucasian Hospital Admission Time: 2015-XX-XX 12:03:00 Hospital Admission Source: Emergency Department Hospital Discharge Time: 2015-XX-XX 19:19:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admission Time: 2015-XX-XX 13:39:00 Unit Admission Source: Emergency Department Unit Discharge Time: 2015-XX-XX 19:19:00 Unit Discharge Location: Home Unit Discharge Status: Alive

Medical History

Insufficient data to provide a detailed medical history. The provided data focuses primarily on the ICU stay and lacks information on prior medical conditions, surgeries, allergies, family history, or social history. Further information is required to complete this section.

Diagnoses

* **Primary Diagnosis:** Ethanol Overdose (ICD-9 Codes: 980.0, E980.2, T51.0) - This diagnosis was active upon discharge from the ICU. * **Major Diagnosis:** Hypertension (ICD-9 Codes: 401.9, I10) - This diagnosis was active upon discharge from the ICU. Both the ethanol overdose and hypertension diagnoses were initially recorded at approximately 160 minutes after unit admission. Additional entries for these diagnoses exist, but were marked as inactive upon discharge. This suggests a possible initial misdiagnosis or a later reassessment of the patient's condition.

Treatments

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

* **Cardiovascular:** VTE prophylaxis (enoxaparin, compression stockings, compression boots), beta-blocker (propranolol), ACE inhibitor (lisinopril). * **Gastrointestinal:** Stress ulcer prophylaxis (esomeprazole), enteral feeds (oral feeds). * **Pulmonary:** Nicotine patch. * **Neurologic:** Sedative agent (diazepam).

Note that some treatments were active upon discharge (esomeprazole, compression boots, lisinopril, nicotine patch, diazepam, oral feeds), while others were discontinued prior to discharge. The timing of treatment initiation and cessation is not explicitly provided, only the time of entry into the system.

Vital Trends

NULL. Vital sign data (heart rate, blood pressure, temperature, respiratory rate, oxygen saturation) are not included in the provided dataset. This information is crucial for assessing the patient's overall condition and response to treatment and is needed to populate this section.

Lab Trends

The following lab results were recorded approximately 902 minutes post-unit admission:

* Total bilirubin: 0.2 mg/dL * Creatinine: 0.8 mg/dL * Sodium: 142 mEq/L * Glucose: 123 mg/dL * Albumin: 4.3 g/dL * Hct: 39.6 % * WBC x 1000: 3.8 K/mcL * BUN: 3 mg/dL

The following ABG lab results were recorded at approximately 159 minutes post-unit admission:

* O2 Sat (%): 96 % * FiO2 (%): 21 % * Respiratory Rate: 19 /min

Further lab data over time is needed to establish trends and assess their significance.

Microbiology Tests

NULL. No microbiology test data was provided.

Physical Examination Results

The physical exam was documented as “Performed - Structured”. Additional details regarding specific findings are absent. The Glasgow Coma Scale (GCS) was scored with Eyes 4, Verbal 5, Motor 6, indicating a relatively good neurological status at the time of the assessment. Respiratory mode was noted as spontaneous. More comprehensive physical exam data is needed to provide a thorough assessment.