

## **\*\*Medical Report for Patient 004-10029\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 418417 \* \*\*Unique Patient ID:\*\* 004-10029 \* \*\*Gender:\*\* Female \* \*\*Age:\*\* 57 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital Admission Time:\*\* 2015-XX-XX 00:20:00 \* \*\*Hospital Admission Source:\*\* Emergency Department \* \*\*Hospital Discharge Time:\*\* 2015-XX-XX 16:35:00 \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admission Time:\*\* 2015-XX-XX 11:57:00 \* \*\*Unit Admission Source:\*\* Emergency Department \* \*\*Unit Discharge Time:\*\* 2015-XX-XX 21:12:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Admission Weight:\*\* 73.94 kg \* \*\*Admission Height:\*\* 162.5 cm

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

NULL. The provided data does not contain a patient history section.

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

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis was pneumonia (ICD-9 code: 486, J18.9), initially recorded at 60 minutes post-unit admission. This diagnosis remained active upon discharge. Other significant diagnoses included:

\* \*\*Pneumonia (Major):\*\* Multiple entries for pneumonia, both primary and major diagnoses, suggest a persistent and significant respiratory issue. \* \*\*Transient Ischemic Attack (TIA) (Major):\*\* Multiple entries over the course of the stay indicate episodes of TIA, potentially reflecting underlying cerebrovascular disease. ICD-9 codes: 435.9, G45.9 \* \*\*Hematuria (Major):\*\* This diagnosis, indicating blood in the urine, also had multiple entries (ICD-9 codes: 599.7, R31.9), suggesting a urinary tract complication or underlying renal issue.

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

The patient received a wide range of treatments during their ICU stay. Key treatments included:

\* \*\*Antibiotics:\*\* Levofloxacin and Ceftriaxone were administered to address the pneumonia, suggesting a bacterial infection. The timing of these treatments aligns with the diagnosis. \* \*\*Pain Management:\*\* Both narcotic and non-narcotic analgesics (ketorolac and acetaminophen) were administered throughout the stay, indicating pain management was a significant aspect of care. \* \*\*Antiemetics:\*\* Ondansetron was used, suggesting nausea and vomiting were managed. \* \*\*Respiratory Support:\*\* Oxygen therapy (nasal cannula and higher concentrations) was administered, reflecting respiratory compromise due to pneumonia. \* \*\*Fluid Management:\*\* Normal saline administration was used, likely for fluid balance maintenance. \* \*\*VTE Prophylaxis:\*\* Compression stockings were used to prevent venous thromboembolism, a common preventative measure in hospitalized patients. \* \*\*Anticonvulsants:\*\* Valproate and Gabapentin were administered, suggesting seizure prophylaxis or management was necessary due to the TIA. \* \*\*Stress Ulcer Prophylaxis:\*\* Pantoprazole was administered to prevent stress ulcers, a common complication in critically ill patients. \* \*\*Imaging:\*\* Abdominal and pelvic CT scans were performed, likely to investigate the underlying causes of the various diagnoses.

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

NULL. Vital sign trends are not available in the provided data.

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

The following lab results were available:

\* \*\*Creatinine (mg/dL):\*\* 1.0 mg/dL \* \*\*Albumin (g/dL):\*\* 2.5 g/dL \* \*\*Sodium (mEq/L):\*\* 139 mEq/L \* \*\*Glucose (mg/dL):\*\* 113 mg/dL \* \*\*Total Bilirubin (mg/dL):\*\* 0.6 mg/dL \* \*\*WBC x 1000 (K/mcL):\*\* 17.2 K/mcL \* \*\*FiO2 (%):\*\* 28% \* \*\*Hct (%):\*\* 35.1% \* \*\*BUN (mg/dL):\*\* 35 mg/dL

NULL. Trends over time cannot be determined from the single time point lab data.

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

Blood and urine cultures were obtained, indicating an attempt to identify the causative organism of the infection. Results of these tests are not included in the data.

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

The physical exam was performed and documented. Vital signs recorded include:

\* \*\*Heart Rate (HR):\*\* 69-70 bpm \* \*\*Blood Pressure (BP):\*\* 78/48 - 87/53 mmHg \* \*\*Respiratory Rate (RR):\*\* 14-15 breaths/min \* \*\*Oxygen Saturation (O2 Sat):\*\* 94-96% \* \*\*Weight:\*\* 73.94 kg \* \*\*Glasgow Coma Scale (GCS):\*\* 15 (Eyes: 4, Verbal: 5, Motor: 6)

The physical exam was noted as 'Performed - Structured'. More detailed findings are not available in the provided data.