

## **\*\*Patient Medical Report\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 343093 \* \*\*Patient Health System Stay ID:\*\* 295227 \* \*\*Unique Patient ID:\*\* 004-11474 \*  
\*\*Gender:\*\* Male \* \*\*Age:\*\* 73 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 131 \* \*\*Ward ID:\*\* 227 \* \*\*Unit Type:\*\*  
Med-Surg ICU \* \*\*Unit Admit Time:\*\* 01:48:00 \* \*\*Unit Admit Source:\*\* Direct Admit \* \*\*Unit Discharge Time:\*\* 23:14:00 \*  
\*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Time:\*\* 01:47:00 \* \*\*Hospital Admit  
Source:\*\* Direct Admit \* \*\*Hospital Discharge Year:\*\* 2015 \* \*\*Hospital Discharge Time:\*\* 09:00:00 \* \*\*Hospital Discharge  
Location:\*\* Death \* \*\*Hospital Discharge Status:\*\* Expired \* \*\*Admission Weight:\*\* 77.65 kg \* \*\*Admission Height:\*\* 177.8  
cm

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

The provided data does not contain a detailed patient history. To generate a complete History section, additional information is needed, such as the reason for admission to the hospital and ICU, previous medical conditions, family history, social history (e.g., smoking, alcohol use), and any relevant symptoms experienced by the patient before and during the ICU stay. The APACHE admission diagnosis only indicates the patient was admitted for weaning from mechanical ventilation, implying a previous respiratory event or illness requiring intubation. Further details are required to elucidate the complete medical history. The multiple diagnoses listed in the subsequent section suggest a complex medical picture requiring a more comprehensive history to understand the chronological progression and interrelationships of the conditions.

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

The patient presented with multiple diagnoses during their ICU stay. The diagnoses, listed in order of priority (Primary, Major, or Other), were:

\* \*\*Primary:\*\* Pulmonary|Respiratory Failure|Failure to Wean (multiple entries at different times) \* \*\*Major:\*\*  
Hematology|Bleeding and Red Blood Cell Disorders|Anemia (multiple entries) \* \*\*Major:\*\* Cardiovascular|Vascular  
Disorders|DVT|Right Lower Extremity (multiple entries) \* \*\*Major:\*\* Cardiovascular|Ventricular Disorders|Congestive Heart  
Failure (multiple entries) \* \*\*Major:\*\* Gastrointestinal|Post-GI Surgery|S/P Exploratory Laparoscopy (multiple entries) \*  
\*\*Other:\*\* Cardiovascular|Chest Pain|ASHD|Hyperlipidemia (multiple entries) \* \*\*Other:\*\* Cardiovascular|Ventricular  
Disorders|Hypertension (multiple entries)

The lack of ICD-9 codes for several diagnoses (Respiratory Failure and Exploratory Laparoscopy) hinders a complete understanding of the specific subtypes of these conditions. The presence of multiple cardiovascular, pulmonary, and hematological diagnoses indicates a complex clinical picture. The timing of diagnosis entries (indicated by `diagnosisoffset`) could reveal the order in which these conditions were identified and treated, and further analysis might reveal correlations between the different conditions. A more detailed description of each diagnosis and their severity is needed for a comprehensive medical report. The fact that none of the diagnoses were active upon discharge suggests that the patient's condition improved before their death.

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

The patient received a variety of treatments, including:

\* \*\*Pulmonary:\*\* Oxygen therapy (at varying concentrations), ventilator weaning, tracheal suctioning, bronchodilator medications. \* \*\*Cardiovascular:\*\* Cardiology consultation, VTE prophylaxis (compression boots). \* \*\*Renal:\*\* Nephrology consultation, Foley catheter placement. \* \*\*Infectious Diseases:\*\* Infectious Disease consultation, cultures, vascular catheter placement. \* \*\*General:\*\* Physical therapy consultation.

The 'activeupondischarge' flag for all treatments is 'False', signifying that these treatments were discontinued before the patient's death. The timing of these interventions is not fully described in the provided data, and a more detailed timeline

would enhance understanding of the treatment strategy. Further information regarding medication dosages, response to treatment, and any complications from treatments would be beneficial for a comprehensive report.

**\*\*5. Vital Trends, Lab Trends, Microbiology Tests, Physical Examination Results\*\***

NULL. The provided dataset lacks the time-series data for vital signs (e.g., heart rate, blood pressure, respiratory rate, oxygen saturation) and detailed lab results necessary to construct these sections of the report. Similarly, information on microbiology tests and a complete physical examination is missing.

**\*\*Note:\*\*** This report highlights the limitations of the provided data. A comprehensive medical report requires a more complete dataset encompassing detailed history, vital signs, a complete physical examination, microbiology results, and comprehensive lab results over time. The absence of these data points prevents a complete evaluation of the patient's condition and the efficacy of their treatment.