Medical Report: Patient 004-13216

1. Patient Information

* **Patient Unit Stay ID:** 345142 * **Unique Patient ID:** 004-13216 * **Gender:** Female * **Age:** 77 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 21:19:00 * **Hospital Admission Source:** Other Hospital * **Hospital Discharge Time:** 2015, 21:08:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015, 21:19:00 * **Unit Admission Source:** Other Hospital * **Unit Discharge Time:** 2015, 21:08:00 * **Unit Discharge Location:** Skilled Nursing Facility * **Unit Discharge Status:** Alive * **Admission Height:** 162.6 cm * **Admission Weight:** 134.8 kg

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon discharge was 'pulmonary|respiratory failure|failure to wean'. Other major diagnoses included:

* **Neurologic:** Post-neurosurgery (post craniotomy), disorders of vasculature (cerebral subdural hematoma secondary to anticoagulation) * **Pulmonary:** Respiratory failure (hypoxemia), respiratory failure (failure to wean), pleural effusion, Tracheostomy performed during this admission for ventilatory support

The timing of diagnosis entries varied, with some recorded shortly after unit admission and others later in the stay. Specific ICD-9 codes were provided for some diagnoses (799.02, J96.91, 432.1, I62.1, 31.1), however, many were missing, indicating incomplete documentation or reliance on the eCareManager pathstring for diagnosis identification. The diagnosis priority indicates the relative importance assigned to each diagnosis by the medical team.

4. Treatments

The patient received a comprehensive range of treatments addressing her multiple diagnoses. These treatments included:

* **Pulmonary:** Mechanical ventilation, oxygen therapy (various concentrations), tracheal suctioning, bronchodilator medications, thoracentesis, chest x-rays, bronchoscopy, and consultations with Pulmonary/CCM. * **Neurologic:** EEG, Neurology consultations, anticonvulsant medications (phenytoin and levetiracetam). * **Cardiovascular:** IV furosemide, labetalol, metoprolol, amiodarone, and VTE prophylaxis (compression boots and stockings). * **General:** Physical and occupational therapy consults.

Several treatments were active upon discharge, specifically antifungal therapy, EEG, IV furosemide, and VTE prophylaxis (compression stockings). The detailed treatment information shows a multidisciplinary approach to patient care. The lack of dosage and duration information in the provided data limits the comprehensive analysis of treatment efficacy.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

The provided lab data includes multiple complete blood count (CBC) results, along with chemistry panels and arterial blood gas (ABG) results at various points throughout the patient's stay. Specific values are detailed in the table below. Note that many lab results are missing, which is a limitation of this report.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

The physical exam documented vital signs, including heart rate (83-86 bpm), systolic blood pressure (125 mmHg), diastolic blood pressure (53 mmHg), and oxygen saturation (97-98%). A Glasgow Coma Scale (GCS) score of 14 was recorded, with individual scores of 4 for eyes, 4 for verbal, and 6 for motor responses. Respiratory rate was documented as 31 breaths per minute, with PEEP set at 5 cm H2O. The ventilator rate was 15 breaths per minute and tidal volume was 550 mls. The physical exam was performed in a structured manner.

Note: The absence of additional physical exam data and the limited nature of the data provided prevents a more thorough evaluation of the patient's progress and response to therapy.