**Patient Information**

Patient Unit Stay ID: 262775 Unique Patient ID: 003-19124 Gender: Male Age: 48 Ethnicity: Native American Hospital Admit Time: 2015-XX-XX 18:09:00 Hospital Discharge Time: 2015-XX-XX 17:57:00 Unit Type: Med-Surg ICU Unit Admit Time: 2015-XX-XX 19:38:00 Unit Discharge Time: 2015-XX-XX 13:06:00 Admission Weight: 63.7 kg Discharge Weight: 65.5 kg Admission Height: 170.18 cm Hospital Admit Source: Floor Unit Admit Source: Floor Hospital Discharge Location: Home Unit Discharge Location: Floor Hospital Discharge Status: Alive Unit Discharge Status: Alive

**Medical History**

Insufficient data provided for a detailed medical history. The provided data only includes diagnoses and treatments during the ICU stay, not a comprehensive past medical history. Further information is needed, such as family history, social history, past illnesses, surgeries, allergies, and current medications outside of the ICU stay. The admission diagnosis for the hospital stay was Diabetic Ketoacidosis (DKA), suggesting a history of diabetes.

**Diagnoses**

The patient presented with multiple diagnoses during their ICU stay. The diagnoses, listed in order of priority, are:

1. **Primary Diagnosis:** Diabetic Ketoacidosis (DKA) (ICD-9 code: 250.13, E10.1). This was an active diagnosis upon discharge from the unit. 2. **Other Diagnoses:** * Metabolic acidosis (ICD-9 code: 276.2, E87.2). This was active upon discharge. * Metabolic acidosis (ICD-9 code: 276.2, E87.2). This was not active upon discharge. * Diabetes Mellitus. This was active upon discharge. * Diabetes Mellitus. This diagnosis was entered at 1428 minutes after unit admission and was not active upon discharge. * Diabetes Mellitus. This diagnosis was entered at 88 minutes after unit admission and was not active upon discharge. * Abdominal pain/tenderness (ICD-9 code: 789.00, R10.9). This was active upon discharge. * Abdominal pain/tenderness (ICD-9 code: 789.00, R10.9). This was not active upon discharge. * Abdominal pain/tenderness (ICD-9 code: 789.00, R10.9). This was not active upon discharge.

The presence of multiple entries for the same diagnosis suggests that the diagnoses may have evolved or been refined over the course of the patient's stay. The temporal information (diagnosisoffset) would be useful in creating a timeline of diagnostic evolution.

**Treatments**

The patient received various treatments during their ICU stay. These include:

* Continuous insulin infusion (Ended) * D5 half-normal saline intravenous fluid administration (Ended) * Oral analgesics (Ended) * VTE prophylaxis (Active upon discharge) * Promethazine (Ended) * Ondansetron (Ended) * Normal saline administration (Ended) * D50 glucose administration (Ended) * Nicotine patch (Ended) * Narcotic analgesic (Ended) * Low molecular weight heparin (Enoxaparin) for VTE prophylaxis (Ended) * Foley catheter (Ended)

The treatment timeline, based on 'treatmentoffset', would provide valuable insights into the management strategy. The fact that VTE prophylaxis was active on discharge suggests a focus on preventing blood clots.

**Vital Trends**

NULL. No vital sign data is provided.

**Lab Trends**

The provided lab data includes multiple bedside glucose measurements, complete blood counts (CBC), and basic metabolic panels (BMP) performed at various time points during the patient's stay. The glucose levels show significant

fluctuations, ranging from 98 mg/dL to 438 mg/dL, indicating challenges in glucose control. Additional analysis of the complete blood count (CBC) data and basic metabolic panels (BMPs) is needed to assess trends in other key parameters, and to better understand the patient's overall metabolic status.

**Microbiology Tests**

NULL. No microbiology test data is provided.

**Physical Examination Results**

The physical examination recorded the patient's admission weight as 63.7 kg. A later exam, performed 51 minutes after unit admission, indicated a heart rate between 106 and 108 bpm, a systolic blood pressure between 137 and 141 mmHg, and a diastolic blood pressure between 75 and 90 mmHg. Respiratory rate was between 26 and 28 breaths per minute, and oxygen saturation was 100%. The patient was described as healthy-appearing, well-developed, not in acute distress, with normal LOC and oriented x3. This indicates a relatively stable presentation at that point in time. The weight remained stable at 63.7kg throughout the initial period. Further physical exam data would be needed to provide a more comprehensive assessment.