

## **\*\*Medical Report for Patient 002-10287\*\***

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

**\*\*Patient ID:\*\*** 002-10287 **\*\*Patient Unit Stay ID:\*\*** 169975 **\*\*Patient Health System Stay ID:\*\*** 151162 **\*\*Gender:\*\*** Male **\*\*Age:\*\*** 56 **\*\*Ethnicity:\*\*** Asian **\*\*Hospital ID:\*\*** 69 **\*\*Ward ID:\*\*** 98 **\*\*Admission Diagnosis:\*\*** NULL **\*\*Admission Height:\*\*** 157.5 cm **\*\*Hospital Admit Time:\*\*** 2015-XX-XX 12:11:00 (Hospital Admit Offset: -2969 minutes from unit admit) **\*\*Hospital Admit Source:\*\*** Emergency Department **\*\*Hospital Discharge Year:\*\*** 2015 **\*\*Hospital Discharge Time:\*\*** 2015-XX-XX 22:00:00 (Hospital Discharge Offset: 1940 minutes from unit admit) **\*\*Hospital Discharge Location:\*\*** Skilled Nursing Facility **\*\*Hospital Discharge Status:\*\*** Alive **\*\*Unit Type:\*\*** Med-Surg ICU **\*\*Unit Admit Time:\*\*** 2015-XX-XX 13:40:00 **\*\*Unit Admit Source:\*\*** ICU to SDU **\*\*Unit Visit Number:\*\*** 2 **\*\*Unit Stay Type:\*\*** stepdown/other **\*\*Admission Weight:\*\*** NULL **\*\*Discharge Weight:\*\*** NULL **\*\*Unit Discharge Time:\*\*** 2015-XX-XX 23:02:00 (Unit Discharge Offset: 562 minutes from unit admit) **\*\*Unit Discharge Location:\*\*** Floor **\*\*Unit Discharge Status:\*\*** Alive

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

Insufficient information provided to generate a detailed medical history. The provided data only includes timestamps and locations of admission and discharge, not the patient's presenting symptoms, past medical history, family history, or social history. Further information is needed.

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

NULL. No diagnoses are listed in the provided data.

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

NULL. No treatment information is included in the dataset.

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

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is available in the provided data.

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

The following laboratory results were obtained:

**\*\*Hematology:\*\*** The complete blood count (CBC) revealed: \* WBC: 5.3 K/mcL \* RBC: 4.09 M/mcL \* Hgb: 13 g/dL \* Hct: 37.9 % \* MCV: 92.7 fL \* MCH: 31.8 pg \* MCHC: 34.3 g/dL \* RDW: 13.7 % \* Platelets: 148 K/mcL \* Differential: \* -Lymphs: 34 % \* -Monos: 11 % \* -Granulocytes: \* -Polys: 52 % \* -Eos: 2 % \* -Basos: 1 % **\*\*Chemistry:\*\*** \* Bedside glucose measurements were taken at multiple time points during the stay, showing varying levels. (See Lab Trends table below for details.)

The lab results were obtained approximately 1246 minutes after unit admission, except for bedside glucose which varied. The time indicates a single time point of blood draw, not a trend over time. To assess trends, longitudinal data is required over multiple time points. The significance of these values is impossible to determine without additional clinical context and comparison to reference ranges.

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

NULL. No microbiology test results are provided.

**\*\*8. Physical Examination Results:\*\***

NULL. No physical examination results are included in the provided data.