

****Patient Information****

Patient Unit Stay ID: 242895 Unique Patient ID: 003-10368 Gender: Male Age: 80 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 17:00:00 Hospital Discharge Time: 2015-XX-XX 17:35:00 Unit Admit Time: 2015-XX-XX 16:18:00 Unit Discharge Time: 2015-XX-XX 18:41:00 Admission Weight: 101.2 kg Discharge Weight: 101.2 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 Unit Type: Med-Surg ICU

****Medical History****

NULL (Insufficient data provided for a detailed medical history. The provided data focuses primarily on diagnoses, treatments, and lab results during the ICU stay, not the patient's broader medical history prior to admission.)

****Diagnoses****

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon admission, and remaining active upon discharge, was Atrial Fibrillation (ICD-9 codes: 427.31, I48.0) Other diagnoses included:

* Obstructive Sleep Apnea (ICD-9 codes: 780.57, G47.33): This diagnosis was recorded multiple times throughout the stay, both active and inactive at different points. * COPD (ICD-9 codes: 491.20, J44.9): Similar to OSA, this diagnosis was recorded at various times with varying activity status. * Atrial Fibrillation without hemodynamic compromise (ICD-9 codes: 427.31, I48.0): This diagnosis was present at various points in the ICU stay. * Bradycardia (ICD-9 code:): This diagnosis was also recorded as both active and inactive.

Note that the diagnosis priority indicates the relative severity assigned by the medical team; Atrial Fibrillation was marked as 'Primary' while other conditions were noted as 'Major' or 'Other'. The sequence of diagnosis entries does not necessarily reflect the order of onset or clinical significance.

****Treatments****

The patient received a variety of treatments during their ICU stay. Treatments active upon discharge included:

* Inhaled bronchodilator medication: * Low molecular weight heparin (enoxaparin) for anticoagulation * Transthoracic echocardiography * Electrical cardioversion * Cardiology consultation * Permanent pacemaker implantation

Other treatments administered during the stay but not active upon discharge included:

* Cardiology consultation * External pacemaker * Low molecular weight heparin (enoxaparin) for VTE prophylaxis * Inhaled bronchodilator and albuterol (Proventil, Ventolin) medications

****Vital Trends****

NULL (No vital sign data was provided.)

****Lab Trends****

The provided lab data includes multiple blood tests performed at different times during the patient's ICU stay. The data suggests several trends: Blood glucose levels were consistently elevated, ranging from 77 mg/dL to 181 mg/dL across multiple measurements. Electrolyte levels (sodium, potassium, chloride, bicarbonate, magnesium, calcium) show some variation but mostly remain within typical ranges. Hematological values (Hemoglobin, Hematocrit, RBC, WBC, Platelets) provide a snapshot of blood cell counts and oxygen-carrying capacity. The PT (Prothrombin Time) and INR (International Normalized Ratio) suggest a measure of blood clotting ability, and values are available. ABG values were also recorded

(pH, PaO2, PaCO2, O2 Sat, Base Excess, FiO2) indicating blood gas analysis. More detailed analysis would require time-series data to determine trends over time.

****Microbiology Tests****

NULL (No microbiology test data was provided.)

****Physical Examination Results****

The physical examination documented at 1427 minutes post-unit admission indicated the following:

* Heart Rate (HR): Current 56 bpm, Lowest 48 bpm, Highest 77 bpm; Rhythm: Irregular * Blood Pressure (BP): Systolic Current 140 mmHg, Lowest 92 mmHg, Highest 118 mmHg; Diastolic Current 70 mmHg, Lowest 64 mmHg, Highest 105 mmHg * Respiratory Rate: Current 20 breaths/min, Lowest 15 breaths/min, Highest 26 breaths/min; Mode: Spontaneous * Oxygen Saturation (O2 Sat): Current 94%, Lowest 91%, Highest 100% * Weight: 101.2 kg (both admission and current weight) * Urine output: 1045 ml * GCS: 15 (Score: Scored, Motor: 6, Verbal: 5, Eyes: 4)

An earlier physical exam (at 43 minutes post-unit admission) recorded similar vital signs with slight variations. Weight remained consistent at 101.2 kg. The exam indicated a structured assessment was performed.