\*\*Medical Report: Patient 008-10139\*\*

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

- \* \*\*Patient Unit Stay ID:\*\* 1051785 \* \*\*Unique Patient ID:\*\* 008-10139 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 29 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital Admission Time:\*\* 2015-XX-XX 11:30:00 \* \*\*Hospital Admission Source:\*\* Emergency Department \* \*\*Hospital Discharge Time:\*\* 2015-XX-XX 21:57:00 \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Hospital Discharge Location:\*\* Other \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admission Time:\*\* 2015-XX-XX 13:15:00 \* \*\*Unit Admission Source:\*\* Emergency Department \* \*\*Unit Discharge Time:\*\* 2015-XX-XX 01:25:00 \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Admission Weight:\*\* 83.2 kg \* \*\*Admission Height:\*\* 168 cm
- \*\*2. History:\*\* The patient was admitted to the hospital via the Emergency Department following a drug overdose involving sedatives, hypnotics, antipsychotics, and benzodiazepines. The patient presented in acute distress and was immediately transferred to the Med-Surg ICU. The admission diagnosis was listed as a drug overdose. Further investigation revealed a salicylate overdose/toxicity as a secondary diagnosis. The patient's history prior to admission is not available in this data set. A detailed social history and past medical history is needed to provide complete context for the current situation. Additional information regarding the circumstances surrounding the overdose (e.g., intentional or accidental, presence of other substances) would significantly enhance the understanding of this case. The absence of this information limits the ability to provide a comprehensive history.
- \*\*3. Diagnoses:\*\*
- \* \*\*Primary Diagnosis:\*\* Drug overdose (general) \* \*\*Secondary Diagnosis:\*\* Salicylate overdose/toxicity (ICD-9 codes: 965.1, E980.2, T39.09) Both diagnoses were active upon discharge from the unit.
- \*\*4. Treatments:\*\*
- \* \*\*Psychiatry consultation:\*\* A psychiatry consultation was initiated 279 minutes post-unit admission. Further details on the specific treatment plan implemented are absent from the data. A detailed description of interventions, medications administered (including dosages and administration routes), and any supportive care measures provided is crucial for a thorough medical report. The lack of this information prevents a full account of the patient's treatment.
- \*\*5. Vital Trends:\*\* NULL (Vital signs data not provided in the dataset.)
- \*\*6. Lab Trends:\*\* The following lab results were obtained at 1303 minutes from unit admission time (unless otherwise specified):
- \* \*\*CPK:\*\* 288 Units/L (initial), 229 Units/L (later) Elevated levels indicative of potential muscle damage. The trend shows a decrease in CPK levels over time suggesting improvement. More frequent measurements would be useful to establish a definitive trend. \* \*\*AST (SGOT):\*\* 26 U/L - Mild elevation, suggesting possible liver involvement. A more complete liver panel would be beneficial. \* \*\*Direct Bilirubin: \*\* 0 mg/dL - Within normal limits. \* \*\*Alkaline Phosphatase: \*\* 68 U/L -Elevated levels, potentially indicating liver or bone disease. Further investigation is required. \* \*\*Albumin:\*\* 3.3 g/dL - Low level, suggesting potential malnutrition or liver dysfunction. \* \*\*RBC:\*\* 4.6 M/mcL - Within the normal range. \* \*\*Total Protein:\*\* 5.7 g/dL - Within the normal range. \* \*\*MCV:\*\* 85.9 fL - Slightly elevated, potentially indicative of macrocytosis (larger than normal red blood cells). \* \*\*ALT (SGPT):\*\* 41 U/L - Mild elevation, suggesting possible liver involvement. \* \*\*Hgb:\*\* 13.5 g/dL - Within the normal range. \* \*\*Total Bilirubin:\*\* 0.6 mg/dL - Slightly elevated, suggesting mild liver dysfunction. \* \*\*WBC x 1000:\*\* 15 K/mcL - Elevated indicating an infection or inflammatory response. Further investigation is necessary. \* \*\*Urinary Specific Gravity:\*\* 1.012 - Within the normal range. \* \*\*Hct:\*\* 39.5 % - Within the normal range. \*\*MPV:\*\* 9.6 fL - Within the normal range. \* \*\*Bicarbonate:\*\* 23 mmol/L - Within the normal range. \* \*\*BUN:\*\* 9 mg/dL -Within the normal range. \* \*\*MCH:\*\* 29.3 pg - Within the normal range. \* \*\*Creatinine:\*\* 0.9 mg/dL - Within the normal range. \* \*\*MCHC:\*\* 34.2 g/dL - Within the normal range. \* \*\*Anion Gap:\*\* 9 - Within normal limits. \* \*\*Platelets x 1000:\*\* 349 K/mcL - Within the normal range. \* \*\*Chloride:\*\* 108 mmol/L - Slightly elevated. \* \*\*Salicylate:\*\* 1310 mg/dL (initial), 100 mg/dL (later) - Extremely high initial level is consistent with salicylate toxicity. The decrease in level over time indicates the effectiveness of treatment. \* \*\*Glucose:\*\* 93 mg/dL - Within the normal range. \* \*\*RDW:\*\* 13.5 % - Slightly elevated, suggesting variation in red blood cell size. \* \*\*Calcium:\*\* 8.7 mg/dL - Within the normal range. \* \*\*Sodium:\*\* 140 mmol/L -

Within the normal range. \* \*\*Potassium:\*\* 3.7 mmol/L - Within the normal range.

\*\*7. Microbiology Tests:\*\* NULL (Microbiology test data not provided in the dataset.)

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

A structured physical exam was performed at 258 minutes post-unit admission. The patient was described as ill-appearing but not in acute distress, with a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6). Heart sounds were normal (S1 and S2). Lung sounds were clear. The patient was not intubated. The patient showed no edema and had adequate perfusion. The patient was agitated at times. Initial weight at admission was 83.2 kg. Additional details on the physical exam are lacking. A complete description of the physical exam including all relevant findings is necessary for a comprehensive evaluation. The current data is partial.