Medical Report for Patient 006-101400

1. Patient Information

* **Patient Unit Stay ID:** 650417 * **Patient Health System Stay ID:** 520722 * **Unique Patient ID:** 006-101400 * **Gender:** Male * **Age:** 66 * **Ethnicity:** Caucasian * **Hospital ID:** 171 * **Ward ID:** 335 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 22:30:00 (2015) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 00:42:00 (2015) * **Unit Discharge Location:** ICU * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 20:01:00 (2015) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 20:35:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height (cm):** 177 * **Admission Weight (kg):** 106.8 * **Discharge Weight (kg):** NULL

2. History

The provided data does not contain a detailed patient history. Further information is needed to complete this section. The admission diagnosis listed is "Pneumonia, bacterial." This suggests a likely respiratory illness as the primary reason for admission to the ICU.

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The diagnoses, along with their priority and ICD-9 codes are as follows:

* **Primary Diagnoses:** * Pneumonia, community-acquired (486, J18.9) * Acute respiratory distress (518.82) * Pulmonary embolism (415.19, I26.99) * **Major Diagnoses:** * Acute respiratory distress (518.82) * Hypoxemia (799.02, J96.91) * Pulmonary embolism (415.19, I26.99) * Hypoxemia (799.02, J96.91) * Hypoxemia (799.02, J96.91)

Note that multiple entries for the same diagnosis likely reflect evolving assessment and documentation over the course of the ICU stay. The absence of `activeupondischarge` being 'True' for any diagnosis suggests all were resolved or managed by the time of discharge.

4. Treatments

The data does not provide details about specific treatments administered. Information on medications, respiratory support (e.g., mechanical ventilation, oxygen therapy), and other interventions is missing and required for a complete report.

5. Vital Trends

The available data only includes limited vital signs recorded at a single time point during the physical examination at 310 minutes post-unit admission. These include:

* Heart Rate (HR) Current: 92 bpm * Heart Rate (HR) Lowest: 88 bpm * Heart Rate (HR) Highest: 100 bpm * Blood Pressure (Systolic) Current: 141 mmHg * Blood Pressure (Systolic) Lowest: 128 mmHg * Blood Pressure (Systolic) Highest: 138 mmHg * Blood Pressure (Diastolic) Current: 51 mmHg * Blood Pressure (Diastolic) Lowest: 47 mmHg * Blood Pressure (Diastolic) Highest: 69 mmHg * Respiratory Rate (Resp) Current: 34 breaths/min * Respiratory Rate (Resp) Lowest: 23 breaths/min * Respiratory Rate (Resp) Highest: 40 breaths/min * Oxygen Saturation (O2 Sat%) Current: 90% * Oxygen Saturation (O2 Sat%) Lowest: 89% * Oxygen Saturation (O2 Sat%) Highest: 95%

To generate vital sign trends, a time series of vital signs data is required.

6. Lab Trends

The lab data includes numerous tests performed at various times throughout the patient's stay. A comprehensive analysis requires visualization of these trends over time. The included labs are:

* Ferritin * Base Excess * Platelets * Lipase * paCO2 * pH * MCHC * MCH * Bedside glucose * RDW * MPV * HCO3 * Hct * WBC * BNP * BUN * Calcium * Creatinine * Sodium * Chloride * Albumin * AST (SGOT) * ALT (SGPT) * PT * PT - INR * Transferrin * Lactate * Magnesium * Vancomycin - trough * FiO2 * Respiratory Rate

7. Microbiology Tests

NULL. No microbiology test results are included in the provided data.

8. Physical Examination Results

The physical exam notes indicate that a structured physical exam was performed at 310 minutes post-unit admission and a scored Glasgow Coma Scale (GCS) was recorded (Eyes: 4, Verbal: 5, Motor: 6; Total: 15). The initial physical exam was not performed. Further details of the exam are needed.