

****Medical Report: Patient 006-100326****

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

***Patient Unit Stay ID:** 598212 ***Unique Patient ID:** 006-100326 ***Patient Health System Stay ID:** 489367 *
Gender: Male ***Age:** 30 ***Ethnicity:** Hispanic ***Hospital ID:** 171 ***Ward ID:** 364 ***Admission Diagnosis (APACHE):** NULL ***Admission Height:** 170.1 cm ***Hospital Admit Time:** 2014-XX-XX 15:42:00 (Offset: -590 minutes from unit admit) ***Hospital Admit Source:** Emergency Department ***Hospital Discharge Year:** 2014 *
***Hospital Discharge Time:** 2014-XX-XX 23:56:00 (Offset: 1344 minutes from unit admit) ***Hospital Discharge Location:** Home ***Hospital Discharge Status:** Alive ***Unit Type:** Med-Surg ICU ***Unit Admit Time:** 2014-XX-XX 01:32:00 ***Unit Admit Source:** ICU to SDU ***Unit Visit Number:** 2 ***Unit Stay Type:** stepdown/other *
***Admission Weight:** NULL ***Discharge Weight:** NULL ***Unit Discharge Time:** 2014-XX-XX 13:41:00 (Offset: 729 minutes from unit admit) ***Unit Discharge Location:** Floor ***Unit Discharge Status:** Alive

****2. History:****

Insufficient data provided to generate a detailed patient history. The provided data only includes admission and discharge times and locations, along with some basic demographics. A complete history would require information on presenting complaints, past medical history, family history, social history, and medication history. This information is crucial for understanding the context of the patient's ICU stay and the reasons for the lab tests and treatments administered.

****3. Diagnoses:****

NULL. No diagnoses are listed in the provided data. A complete medical report would include a list of all diagnoses, both confirmed and suspected, with associated ICD codes (if available).

****4. Treatments:****

NULL. The data does not specify treatments received during the ICU stay. A detailed description of all medications, procedures, and other interventions would be necessary for a comprehensive report.

****5. Vital Trends:****

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is available in the dataset. These trends are essential for assessing the patient's physiological stability over time.

****6. Lab Trends:****

The provided lab data shows results from a single time point (approximately 708 minutes post unit admission). The following chemistry and hematology results are available:

***Sodium (mmol/L):** 136 ***Alkaline Phosphatase (Units/L):** 36 ***Total Bilirubin (mg/dL):** 0.6 ***Total Protein (g/dL):** 6.6 ***Albumin (g/dL):** 3.4 ***ALT (SGPT) (Units/L):** 81 ***AST (SGOT) (Units/L):** 38 ***Calcium (mg/dL):** 8.8 ***BUN (mg/dL):** 15 ***Creatinine (mg/dL):** 0.71 ***MPV (fL):** 9.2 ***-Polys (%):** 72 ***RBC (M/mcL):** 4.23 *
***Bicarbonate (mmol/L):** 24 ***MCH (pg):** 33.8 ***-Monos (%):** 11 ***MCV (fL):** 94 ***Anion Gap:** 7 ***MCHC (g/dL):** 35.9 ***-Lymphs (%):** 15 ***Hgb (g/dL):** 14.3 ***Potassium (mmol/L):** 3.9 ***Hct (%):** 39.8 ***-Eos (%):** 1 ***WBC x 1000 (K/mcL):** 10.2 ***Chloride (mmol/L):** 105 ***Acetaminophen (mcg/mL):** <2 (obtained later at 1253 minutes) ***-Basos (%):** 0 ***Platelets x 1000 (K/mcL):** 201 ***Glucose (mg/dL):** 98

To establish trends, serial lab results over time are necessary.

****7. Microbiology Tests:****

NULL. No microbiology test results are provided.

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

NULL. No physical examination findings are included in the data.