

## **\*\*Medical Report for Patient 007-10076\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 961441 \* \*\*Unique Patient ID:\*\* 007-10076 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 65 \* \*\*Ethnicity:\*\* African American \* \*\*Hospital Admit Time:\*\* 2015-10-26 10:49:00 (Hospital ID: 181, Ward ID: 428) \* \*\*Hospital Admit Source:\*\* Recovery Room \* \*\*Hospital Discharge Time:\*\* 2015-10-27 23:30:00 \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* (Assuming Unit Admit Time is derived from the offset values, further data is needed to calculate the exact time) \* \*\*Unit Admit Source:\*\* Other ICU \* \*\*Unit Visit Number:\*\* 3 \* \*\*Unit Stay Type:\*\* transfer \* \*\*Admission Weight:\*\* 142.9 kg \* \*\*Discharge Weight:\*\* 137.8 kg \* \*\*Unit Discharge Time:\*\* (Assuming Unit Discharge Time is derived from the offset values, further data is needed to calculate the exact time) \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Admission Height:\*\* 180.3 cm

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

NULL (Insufficient information provided in the JSON data to reconstruct the patient's medical history. A detailed history would typically include presenting complaints, relevant past medical history, family history, social history, and medication history.)

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

The patient presented with multiple diagnoses. Based on the provided data, the active diagnoses upon discharge were:

\* \*\*Cecum Colon Cancer (ICD-9 Codes: 153.4, C18.0):\*\* Listed as 'Other' priority. The diagnosis was entered 489 minutes after unit admission. \* \*\*Atrial Fibrillation with Rapid Ventricular Response (ICD-9 Codes: 427.31, I48.0):\*\* Listed as 'Other' priority. The diagnosis was entered 489 minutes after unit admission. \* \*\*Post-GI surgery for cancer:\*\* Listed as 'Other' priority. Two entries exist, one at 489 minutes and one at 18 minutes post-unit admission. The 18-minute entry was not active upon discharge. \* \*\*Lower GI Bleeding (ICD-9 Codes: 578.9, K92.2):\*\* Listed as 'Other' priority. Two entries exist, one at 489 minutes and one at 18 minutes post-unit admission. The 18-minute entry was not active upon discharge.

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

The patient received the following treatments during their ICU stay:

\* \*\*Amiodarone:\*\* A Class III antiarrhythmic medication for cardiovascular arrhythmias. This treatment was not active upon discharge. \* \*\*Esophagogastroduodenoscopy (EGD):\*\* A gastrointestinal endoscopic procedure. This treatment was active upon discharge. \* \*\*Gastroenterology Consultation:\*\* A consultation with a gastroenterologist. This treatment was active upon discharge. \* \*\*Analgesics:\*\* Pain medication. This treatment was active upon discharge. \* \*\*Exploratory Laparotomy:\*\* Surgical procedure. This treatment was active upon discharge.

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

NULL (No vital sign data is included in the provided JSON.)

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

The patient underwent multiple laboratory tests, including blood work (complete blood count with differential, glucose, electrolytes, liver function tests, kidney function tests) and coagulation studies (PT, PTT, INR). Multiple measurements were taken at different time points. Trends in these values require visualization and further analysis. (Specific trends will be detailed in the visualization and CSV sections.)

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

NULL (No microbiology test results are included in the provided JSON.)

## **\*\*8. Physical Examination Results\*\***

Physical exams were performed at 14 minutes and 488 minutes post-unit admission. The exams included vital signs (heart rate, blood pressure, respiratory rate, oxygen saturation), a neurological assessment (Glasgow Coma Scale), and weight and intake/output measurements. Specific values are provided for some of these measurements at the time points mentioned.

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\*Note: This report is based solely on the limited data provided. A comprehensive report would require additional clinical information.\*