Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 399713 * **UniquePID:** 004-1044 * **Gender:** Female * **Age:** 75 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015, 19:47:00 * **Hospital Discharge Time:** 2015, 18:10:00 * **Unit Admit Time:** 21:15:00 * **Unit Discharge Time:** 20:45:00 * **Admission Weight:** 64.8 kg * **Admission Height:** 152.4 cm * **Hospital Admit Source:** NULL * **Hospital Discharge Location:** Nursing Home * **Hospital Discharge Status:** Alive * **Unit Admit Source:** Emergency Department * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unit Type:** Med-Surg ICU

2. History

Admission diagnosis was Restrictive lung disease (i.e., Sarcoidosis, pulmonary fibrosis). The patient presented to the Emergency Department and was admitted to the Med-Surg ICU. Further details regarding the patient's medical history prior to this ICU stay are not available in the provided data.

3. Diagnoses

The patient received multiple diagnoses during her ICU stay. These include:

* **Primary:** Congestive Heart Failure (ICD-9 codes: 428.0, I50.9) - This diagnosis was active upon discharge. * **Major:** Acute COPD Exacerbation (ICD-9 codes: 491.21, J44.1) - This diagnosis was not active upon discharge. * **Major:** Atrial Fibrillation (ICD-9 codes: 427.31, I48.0) - This diagnosis was active upon discharge.

Note that the 'Acute COPD Exacerbation' and 'Atrial Fibrillation' diagnoses were recorded multiple times with varying active statuses, likely reflecting the fluctuating nature of these conditions during the patient's stay.

4. Treatments

The patient received a range of treatments, including:

* **Cardiovascular:** IV furosemide (diuretic), transthoracic echocardiography, metoprolol (beta-blocker), enoxaparin (low molecular weight heparin). * **Pulmonary:** Oxygen therapy, azithromycin (macrolide antibiotic), ipratropium (bronchodilator), albuterol (beta-agonist), acetaminophen (analgesic). * **Gastrointestinal:** Ondansetron (antiemetic), oral feeds.

Several of these treatments were continued upon discharge, indicating their importance in managing the patient's ongoing conditions. Specific dosages and administration schedules are not provided.

5. Vital Trends

NULL. Vital signs data (heart rate, blood pressure, respiratory rate, oxygen saturation) are available in the Physical Examination section, but time series data for trends is missing.

6. Lab Trends

NULL. While lab results are available, there is no temporal information (repeated measurements over time) to generate trends. A single set of lab values was recorded at -185 minutes from unit admit time and another at 35 minutes.

* **Initial Labs (-185 minutes):** Creatinine (1 mg/dL), BUN (27 mg/dL), Sodium (143 mEq/L), Potassium (4.1 mEq/L), Glucose (191 mg/dL), Total Bilirubin (0.3 mg/dL), Hemoglobin (12.4 g/dL), Hematocrit (41.5%), WBC (13.7 K/mcL), Albumin (4 g/dL). * **Later Labs (35 minutes):** FiO2 (22%), O2 Saturation (95%).

7. Microbiology Tests

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

8. Physical Examination Results

* **Admission Weight:** 64.8 kg * **Heart Rate:** 112 bpm * **Blood Pressure (Systolic):** 131 mmHg * **Blood Pressure (Diastolic):** 71 mmHg * **Respiratory Rate:** 23 breaths/min * **Oxygen Saturation:** 98% * **FiO2:** 22% * **Respiratory Mode:** Spontaneous * **Glasgow Coma Scale (GCS):** 15 (Eyes: 4, Verbal: 4, Motor: 6) – Indicating full consciousness.

This physical examination was recorded at 37 minutes from unit admit time. Further physical exam data over the course of the hospital stay are not available.