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**Medical Report for Patient 004-15536**
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\*\*1. Patient Information:\*\*

\* \*\*Patient Unit Stay ID:\*\* 376041 \* \*\*Patient Health System Stay ID:\*\* 322320 \* \*\*Gender:\*\* Female \* \*\*Age:\*\* > 89 \*

\*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 120 \* \*\*Ward ID:\*\* 248 \* \*\*Admission Diagnosis:\*\* CVA, cerebrovascular

accident/stroke \* \*\*Admission Height:\*\* 162.5 cm \* \*\*Hospital Admit Time:\*\* 2014-XX-XX 19:13:00 \* \*\*Hospital Discharge

Time:\*\* 2014-XX-XX 21:10:00 \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Unit

Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 2014-XX-XX 19:13:00 \* \*\*Unit Admit Source:\*\* Emergency Department \*

\*\*Unit Discharge Time:\*\* 2014-XX-XX 00:27:00 \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Unit Discharge Location:\*\* Floor \*

\*\*Admission Weight:\*\* 73.3 kg \* \*\*Discharge Weight:\*\* NULL

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

NULL (No detailed history provided in the input data.)

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

The patient presented with multiple diagnoses, some active upon discharge and others resolved during the ICU stay. Active diagnoses at discharge included:

\* \*\*Major:\*\* Anemia (hematology|bleeding and red blood cell disorders|anemia) \* \*\*Major:\*\* Hyperglycemia (endocrine|glucose metabolism|hyperglycemia) (ICD-9: 790.6, R73.9) \* \*\*Major:\*\* Regurgitant Esophagitis (gastrointestinal|esophageal disease|esophagitis|regurgitant) (ICD-9: 530.11, K21.0) \* \*\*Major:\*\* Hyperlipidemia (cardiovascular|chest pain / ASHD|hyperlipidemia) (ICD-9: 272.4, E78.5) \* \*\*Major:\*\* Hypertension (cardiovascular|ventricular disorders|hypertension) (ICD-9: 401.9, I10) \* \*\*Major:\*\* Chronic Renal Insufficiency (renal|disorder of kidney|chronic renal insufficiency) (ICD-9: 585.9, N18.9)

**Primary Diagnoses:** 

\* \*\*Primary:\*\* Hemorrhagic Stroke, Right-Sided (neurologic|disorders of vasculature|stroke|hemorrhagic stroke|right sided) (ICD-9: 432.9, I62.9) This diagnosis was active upon discharge.

Inactive diagnoses included hypertension, regurgitant esophagitis, chronic renal insufficiency, and hyperglycemia (one instance marked as 'other'). The timing of these diagnoses relative to admission is indicated by the `diagnosisoffset` field.

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

The patient received a range of treatments, some active at the time of discharge and others discontinued earlier. Treatments active upon discharge included:

\* Oral Feeds (gastrointestinal|nutrition|enteral feeds|oral feeds) \* Neurosurgery Consultation (neurologic|consultations|Neurosurgery consultation) \* Head CT Scan (neurologic|procedures / diagnostics|head CT scan) \* Calcium Channel Blocker (cardiovascular|hypertension|calcium channel blocker) \* Monitor Vital Capacities for Deterioration (neurologic|neuromyopathy therapy|monitor vital capacities for deterioration) \* Chest X-Ray (pulmonary|radiologic procedures / bronchoscopy|chest x-ray) \* Compression Stockings (cardiovascular|vascular disorders|VTE prophylaxis|compression stockings) \* Pantoprazole (gastrointestinal|medications|stress ulcer prophylaxis|pantoprazole) \* Nicardipine (cardiovascular|hypertension|vasodilating agent - IV|nicardipine) \* IV Furosemide (cardiovascular|ventricular dysfunction|intravenous diuretic|IV furosemide) \* Simvastatin (cardiovascular|myocardial ischemia / infarction|antihyperlipidemic agent|HMG-CoA reductase inhibitor|simvastatin) \* Valsartan (cardiovascular|hypertension|angiotensin II receptor blocker (ARB)|valsartan) \* Antihypertensive Combination Agent (cardiovascular|hypertension|antihypertensive combination agent) \* Potassium (cardiovascular|arrhythmias|electrolyte administration|potassium)

Inactive treatments included nicardipine, a Neurosurgery consultation, a head CT scan, oral feeds, stress ulcer prophylaxis with pantoprazole, and others as indicated by the `activeupondischarge` and `treatmentoffset` fields.

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

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

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

Laboratory results are available for several parameters at a single time point (approximately 92 minutes post-admission for most, with some at 98 minutes and 62 minutes). These include:

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* **Sodium:** 142 mEq/L * **Potassium:** 3.8 mEq/L * **Chloride:** 101 mEq/L * **Total Bilirubin:** 0.4 mg/dL * **Calcium:** 10.6 mg/dL * **Creatinine:** 1.2 mg/dL * **BUN:** 23 mg/dL * **Glucose:** 162 mg/dL * **Hgb:** 12.1 g/dL * **Hct:** 34.4 % * **Albumin:** 4.4 g/dL * **FiO2:** 21 % * **WBC x 1000:** 5.5 K/mcL
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Additional lab data may be present in the 'customLab' table (not included in this report).

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

NULL (No microbiology data is provided in the input JSON.)

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

The physical exam was performed and documented. A Glasgow Coma Scale (GCS) was recorded with the following scores: Eyes: 4, Verbal: 5, Motor: 6. This suggests a moderate level of neurological impairment. The exam was documented as a 'Performed - Structured' exam.