

## **\*\*Patient Medical Report\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 403279 \* \*\*Patient Health System Stay ID:\*\* 344634 \* \*\*Gender:\*\* Female \* \*\*Age:\*\* 52 \*  
\* \*\*Ethnicity:\*\* African American \* \*\*Hospital ID:\*\* 138 \* \*\*Ward ID:\*\* 195 \* \*\*Admission Diagnosis:\*\* Sepsis, renal/UTI  
(including bladder) \* \*\*Admission Height:\*\* 162.5 cm \* \*\*Hospital Admit Time:\*\* 2014-XX-XX 13:06:00 \* \*\*Hospital Admit  
Source:\*\* Emergency Department \* \*\*Hospital Discharge Year:\*\* 2014 \* \*\*Hospital Discharge Time:\*\* 2014-XX-XX  
00:42:00 \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \*  
\* \*\*Unit Admit Time:\*\* 2014-XX-XX 16:21:00 \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Visit Number:\*\* 1 \*  
\* \*\*Unit Stay Type:\*\* Admit \* \*\*Admission Weight:\*\* 72.7 kg \* \*\*Discharge Weight:\*\* NULL \* \*\*Unit Discharge Time:\*\*  
2014-XX-XX 16:55:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Unique Patient ID:\*\*  
004-11678

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

NULL (Insufficient data provided to reconstruct a detailed patient history.)

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

\* \*\*Primary Diagnosis:\*\* Lower Urinary Tract Infection (595.9, N30.9) \* \*\*Major Diagnoses:\*\* \* Burns/Trauma/Pressure  
Sore (707.00, L89.90) \* Neuromuscular Disorders/Motor Neuropathy/Multiple Sclerosis (340, G35) \* Severe Hypokalemia  
(< 2.8 mEq/L) (276.7, E87.8) \* Diabetes Mellitus

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

\* \*\*Analgesics (Acetaminophen):\*\* For pain/agitation/altered mentation. \* \*\*Oral Electrolyte Correction (Potassium):\*\* For  
electrolyte imbalance. \* \*\*Stress Ulcer Prophylaxis (Omeprazole):\*\* For gastrointestinal protection. \* \*\*Anticoagulant  
Administration (Coumadin):\*\* For coagulation and platelet management. \* \*\*Therapeutic Antibacterials  
(Piperacillin/Tazobactam):\*\* For infectious disease treatment. \* \*\*Sedative Agent (Diazepam):\*\* For pain/agitation/altered  
mentation. \* \*\*Oral Diuretic (Furosemide):\*\* For renal management. \* \*\*Foley Catheter:\*\* For urinary management. \*  
\* \*\*Angiotensin II Receptor Blocker (Telmisartan):\*\* For hypertension.

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

\* \*\*Heart Rate (HR):\*\* Current: 73 bpm, Lowest: 73 bpm, Highest: 74 bpm \* \*\*Blood Pressure (BP):\*\* Systolic - Current:  
168 mmHg, Lowest: 168 mmHg, Highest: 168 mmHg; Diastolic - Current: 88 mmHg, Lowest: 88 mmHg, Highest: 88  
mmHg \* \*\*Respiratory Rate:\*\* Current: 17 breaths/min \* \*\*Oxygen Saturation (O2 Sat):\*\* Current: 98%, Lowest: 98%,  
Highest: 99% \* \*\*Weight:\*\* Admission: 72.7 kg \* \*\*Glasgow Coma Scale (GCS):\*\* Total Score: 15 (Eyes: 4, Verbal: 5,  
Motor: 6) \* \*\*Respiratory Mode:\*\* Spontaneous \* \*\*Heart Rhythm:\*\* Sinus

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

\* \*\*Sodium:\*\* 142 mEq/L \* \*\*Glucose:\*\* 90 mg/dL \* \*\*Creatinine:\*\* 1.0 mg/dL \* \*\*BUN:\*\* 15.01 mg/dL \* \*\*Hematocrit  
(Hct):\*\* 34.4% \* \*\*Total Bilirubin:\*\* 0.5 mg/dL \* \*\*White Blood Cell Count (WBC):\*\* 9.7 K/mcL \* \*\*FiO2:\*\* 21% \*  
\* \*\*Potassium:\*\* 2.6 mEq/L

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

NULL (No microbiology test data provided.)

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

A structured physical exam was performed. Vital signs including heart rate, blood pressure, respiratory rate, and oxygen saturation were recorded. A GCS score of 15 was documented. Weight was recorded at admission. The patient's respiratory mode was spontaneous and heart rhythm was sinus.