Patient Medical Report

1. Patient Information:

* **Patient Unit Stay ID:** 334902 * **Unique Patient ID:** 004-13127 * **Gender:** Male * **Age:** 42 * **Ethnicity:** NULL * **Hospital ID:** 123 * **Ward ID:** 175 * **Unit Type:** Med-Surg ICU * **Admission Height (cm):** 177.8 * **Admission Weight (kg):** 75.8 * **Hospital Admission Time:** 2015-XX-XX 08:19:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 16:20:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Admission Time:** 2015-XX-XX 14:38:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 16:20:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Diagnosis:** Bleeding, upper GI

2. History:

NULL (Insufficient information provided)

3. Diagnoses:

The patient presented with several diagnoses during his ICU stay. The primary diagnoses, both active upon discharge, were upper GI bleeding (ICD-9 codes 456.0, I85.01) and viral hepatitis C (ICD-9 codes 573.1, 070.51, B17.1). Other diagnoses included altered mental status/agitation (ICD-9 codes 308.2, F43.0), coagulopathy (ICD-9 codes 286.9, D68.9), thrombocytopenia (ICD-9 codes 287.5, D69.6), and hypertension (ICD-9 codes 401.9, I10). Some diagnoses, like coagulopathy and Hepatitis C, were initially recorded early in the stay and later re-evaluated. Note that the 'diagnosisPriority' field does not consistently reflect the clinical significance of the conditions.

4. Treatments:

The patient received a range of treatments throughout his ICU stay. Active treatments upon discharge included packed red blood cells transfusion of >2 units, platelet concentrate administration, analgesics, ondansetron (serotonin antagonist), promethazine (antiemetic), octreotide (hormonal therapy for varices), lorazepam (sedative), normal saline administration, and pantoprazole (stress ulcer prophylaxis). Early treatments included similar medications and intravenous fluids, suggesting a consistent treatment plan to address the primary diagnoses.

5. Vital Trends:

NULL (Insufficient information provided - vital signs are needed)

6. Lab Trends:

The following lab values were recorded:

* **Creatinine:** 0.8 mg/dL * **Sodium:** 142 mmol/L * **Albumin:** 3.3 g/dL * **WBC x 1000:** 5.7 K/mcL * **BUN:** 15 mg/dL * **Hct:** 41.7 % * **Glucose:** 102 mg/dL * **Total Bilirubin:** 1.7 mg/dL * **FiO2:** 21 %

Note that these lab results represent a single point in time and do not show trends. More data points are needed to assess trends over the patient's stay.

7. Microbiology Tests:

NULL (Insufficient information provided)

8. Physical Examination Results:

A structured physical examination was performed. The patient's admission weight was recorded as 75.8 kg. A Glasgow Coma Scale (GCS) score of 15 was documented (Eyes 4, Verbal 5, Motor 6). Other observations included spontaneous respiration, a heart rate of 71 bpm, a systolic blood pressure of 111 mmHg, a diastolic blood pressure of 62 mmHg, a respiratory rate of 20 breaths per minute, and an O2 saturation of 95%. The FiO2 was 21%.