Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 343125 * **Unique Patient ID:** 004-15260 * **Gender:** Female * **Age:** 18 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-XX-XX 10:05:00 * **Hospital Discharge Time:** 2014-XX-XX 13:51:00 * **Unit Admission Time:** 2014-XX-XX 10:05:00 * **Unit Discharge Time:** 2014-XX-XX 21:34:00 * **Unit Type:** Med-Surg ICU * **Admission Weight:** 56.8 kg * **Discharge Weight:** NULL * **Admission Height:** 152.4 cm * **Hospital Admission Source:** NULL * **Unit Admission Source:** Emergency Department * **Hospital Discharge Location:** Home * **Unit Discharge Location:** Floor * **Hospital Discharge Status:** Alive * **Unit Discharge Status:** Alive

2. History

Admission diagnosis was Hypertension, uncontrolled (for cerebrovascular accident-see Neurological System). Further details regarding the patient's medical history prior to this ICU stay are not available in the provided data. A more complete history would be necessary for a thorough assessment.

3. Diagnoses

* **Primary Diagnosis:** Headache (ICD-9 code: R51), entered 88 minutes after unit admission. Active upon discharge. * **Major Diagnosis:** Hypertension (ICD-9 code: 401.9, I10), entered 88 minutes after unit admission. Active upon discharge.

4. Treatments

* **Oral Analgesics:** Administered for pain/agitation/altered mentation. Active upon discharge. Specific medication not provided. * **Lumbar Puncture:** Performed as a procedure/diagnostic. Active upon discharge. Specific results not provided. * **Diazepam:** Administered as an anticonvulsant for possible ICH/cerebral infarct. Active upon discharge. Dosage and administration details are missing.

5. Vital Trends

The following vital signs were recorded at 74 minutes post-unit admission:

* **Heart Rate (HR):** Current 122 bpm, Lowest 116 bpm, Highest 123 bpm * **Blood Pressure (BP):** Systolic – Current 139 mmHg, Lowest 139 mmHg, Highest 139 mmHg; Diastolic – Current 85 mmHg, Lowest 85 mmHg, Highest 85 mmHg * **Respiratory Rate (RR):** Current 16 breaths/min, Lowest 16 breaths/min, Highest 22 breaths/min * **Oxygen Saturation (O2 Sat):** Current 97%, Lowest 96%, Highest 99% * **Respiratory Mode:** Spontaneous * **Glasgow Coma Scale (GCS):** Scored; Motor Score 6, Verbal Score 5, Eyes Score 4

Detailed trends over time are not available in the current data set. Continuous monitoring data would be needed for a comprehensive analysis of vital sign trends.

6. Lab Trends

The following lab values were recorded at 494 minutes post-unit admission:

* **Total Bilirubin:** 0.1 mg/dL * **Blood Urea Nitrogen (BUN):** 8 mg/dL * **Albumin:** 3.7 g/dL * **Creatinine:** 0.7 mg/dL * **Sodium:** 145 mEq/L * **Hematocrit (Hct):** 41.5 % * **White Blood Cell count (WBC):** 7.1 K/mcL

Trends over time are unavailable with only a single timepoint. Serial lab results are required to assess trends and evaluate the patient's response to treatment.

7. Microbiology Tests

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

8. Physical Examination Results

A structured physical exam was performed at 74 minutes post unit admission. Specific details beyond the vital signs listed above are not included in the provided data. A complete physical exam would provide more detailed information on the patient's condition.

Note: This report is limited by the information provided. Additional data, such as detailed time-series data for vital signs and lab results, complete medical history, and medication details, would enable a more comprehensive and informative report.