Medical Report: Patient 009-10606

1. Patient Information

* **Patient Unit Stay ID:** 1059195 * **Unique Patient ID:** 009-10606 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-00-00 00:08:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-00-00 19:05:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-00-00 06:39:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-00-00 21:40:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Height:** 170.2 cm * **Admission Weight:** 159.1 kg * **Discharge Weight:** NULL

2. History

The provided data does not contain a detailed patient history. Information is limited to the admission diagnosis, indicating the patient presented with a coma or change in level of consciousness. Further details regarding the onset, duration, and any contributing factors are missing. A comprehensive history, including social history, family history, and past medical history, is crucial for a complete clinical picture and is not available in this dataset. This lack of historical context limits the ability to fully understand the patient's condition and response to treatment.

3. Diagnoses

* **Diagnosis ID:** 15166337 * **Diagnosis String:** neurologic|altered mental status / pain|change in mental status * **ICD-9 Code:** 780.09, R41.82 * **Diagnosis Priority:** Primary * **Active Upon Discharge:** True

The primary diagnosis is altered mental status and pain, possibly related to a change in mental status. The ICD-9 codes suggest a focus on symptoms rather than a definitive underlying etiology. Additional diagnostic information is necessary to establish a precise diagnosis and guide further management. The absence of secondary diagnoses or differential diagnoses also restricts a thorough assessment of the patient's condition.

4. Treatments

* **Treatment ID 1:** 30758164 * **Treatment String:** cardiovascular|non-operative procedures|diagnostic ultrasound of heart * **Active Upon Discharge:** True * **Treatment ID 2:** 30773971 * **Treatment String:** pulmonary|radiologic procedures / bronchoscopy|non-invasive testing for DVT * **Active Upon Discharge:** True * **Treatment ID 3:** 30749817 * **Treatment String:** pulmonary|ventilation and oxygenation|oxygen therapy (< 40%)|nasal cannula * **Active Upon Discharge:** True

The patient received a cardiac ultrasound, non-invasive DVT testing, and nasal cannula oxygen therapy. The specific indications for these treatments are unclear without more clinical context. A detailed record of all administered medications, interventions, and their effectiveness is absent. This prevents a complete evaluation of the treatment plan and its impact on the patient's outcome.

5. Vital Trends NULL

6. Lab Trends

The lab data includes numerous blood tests performed at various time points during the ICU stay. Trends in key parameters such as Hemoglobin (Hgb), Hematocrit (Hct), Platelets, White Blood Cell count (WBC), electrolytes (sodium, potassium, chloride, bicarbonate), creatinine, BUN, glucose, albumin, phosphate, magnesium, lactate, and liver enzymes (ALT, AST) are recorded. However, without the exact time of each measurement in a clear format, it is difficult to provide a structured trend analysis here. The values are also scattered across different times, making a coherent trend analysis impossible in this format. A visual representation would be more effective in showing these trends.

7. Microbiology Tests NULL

8. Physical Examination Results

A structured physical exam was performed. Vital signs recorded include heart rate (HR) between 65 and 85 bpm, systolic blood pressure (BP) between 102 and 120 mmHg, diastolic blood pressure between 48 and 87 mmHg, and respiratory rate (RR) between 13 and 25 breaths per minute. Oxygen saturation (O2 Sat) was between 92% and 98%. The Glasgow Coma Scale (GCS) was scored at 15 (4+5+6). The patient’s admission weight was 159.1 kg. This limited data provides a snapshot of the patient's condition at one point in time, but lacks the longitudinal data necessary for a complete physical examination assessment.