Medical Report for Patient 003-14605

1. Patient Information

* **Patient Unit Stay ID:** 258915 * **Unique Patient ID:** 003-14605 * **Age:** 82 years * **Admission Height:** 175 cm * **Admission Weight:** 99.5 kg * **Hospital Admission Time:** 2014-XX-XX 06:00:00 (Hospital Admit Offset: -142 minutes from unit admit) * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 17:43:00 (Hospital Discharge Offset: 561 minutes from unit admit) * **Hospital Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014-XX-XX 08:22:00 * **Unit Admission Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** Admit * **Unit Discharge Time:** 2014-XX-XX 17:43:00 (Unit Discharge Offset: 561 minutes from unit admit) * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive * **APACHE Admission Dx:** Coma/change in level of consciousness (for hepatic see GI, for diabetic see Endocrine, if related to cardiac arrest, see CV)

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnosis was 'neurologic|altered mental status / pain|change in mental status' (ICD-9 codes: 780.09, R41.82). A major diagnosis was 'neurologic|altered mental status / pain|agitation|severe' (ICD-9 codes: 308.2, F43.0). Other diagnoses included alcohol withdrawal (ICD-9 codes: 291.81, F10.239), leukocytosis (ICD-9 codes: 288.8, D72.829), and obesity (ICD-9 codes: 278.00, E66.9). Several diagnoses of hypotension/pressor dependent, anemia, and lower urinary tract infection were listed but lacked ICD-9 codes and were not active upon discharge. The timing of diagnosis entry, relative to unit admission, varied from 200 to 452 minutes.

4. Treatments

The patient received a variety of treatments during their ICU stay. These included intravenous fluid administration (normal saline), various medications (ciprofloxacin, amoxicillin, lorazepam, ibuprofen, omeprazole, ondansetron, atorvastatin, and aspirin), and procedures such as head CT scan and MRI. The use of vasopressors (dopamine and norepinephrine) is also noted, although specific dosages and durations are not detailed. Importantly, at discharge, the patient was still receiving intravenous fluids (normal saline), lorazepam, and ibuprofen, along with ciprofloxacin and omeprazole. The timing of treatment administration, relative to unit admission, varied widely, reflecting the evolving clinical picture.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

Laboratory results revealed several abnormalities. Chemistry panel results showed an elevated anion gap (10.5 mmol/L) and total bilirubin (1.0 mg/dL). Electrolyte levels were significant, with potassium at 3.1 mmol/L. The patient also presented with leukocytosis (WBC x 1000 = 13.4 K/mcL) and anemia (Hgb = 9.1 g/dL). ABG results show a low blood pH of 7.07 and 7.37 at two different time points. The paCO2 and paO2 values also show fluctuations over time. The creatinine was 1.23 mg/dL. Liver function tests showed slightly elevated AST (32 Units/L) and ALT (29 Units/L). Albumin was 2.5 g/dL. The timing of lab draws varied, with some obtained before unit admission.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

The physical examination at admission noted the patient as ill-appearing but not in acute distress, with irregular heart rhythm and spontaneous respiration. A GCS of 14 was recorded (Eyes 4, Verbal 4, Motor 6), indicating some level of altered mental status and agitation, consistent with the diagnoses. The patient was reported as partially oriented and very agitated/combative. The admission weight was recorded as 99.54 kg.