Patient Medical Report

1. Patient Information:

* **PatientUnitStayID:** 263850 * **PatientHealthSystemStayID:** 226799 * **UniquePID:** 003-10606 * **Gender:** Male * **Age:** 62 * **Ethnicity:** Caucasian * **HospitalID:** 108 * **WardID:** 136 * **Unit Type:** Med-Surg ICU * **Admission Height:** 182.9 cm * **Admission Weight:** 116.7 kg * **Discharge Weight:** 116.8 kg * **Hospital Admit Time:** 2015-XX-XX 16:38:00 (Hospital Admit Offset: -37 minutes from unit admit) * **Hospital Admit Source:** Direct Admit * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 17:30:00 (Hospital Discharge Offset: 7215 minutes from unit admit) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Admit Time:** 2015-XX-XX 17:15:00 * **Unit Admit Source:** Direct Admit * **Unit Visit Number:** 1 * **Unit Stay Type:** Admit * **Unit Discharge Time:** 2015-XX-XX 21:47:00 (Unit Discharge Offset: 6032 minutes from unit admit) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive

2. History:

NULL (Insufficient data provided)

3. Diagnoses:

The patient presented with multiple diagnoses during their ICU stay. These diagnoses, listed in order of diagnosis entry time (not necessarily severity), included:

* **Atrial Fibrillation:** This diagnosis was recorded multiple times, with varying specifications (with rapid ventricular response, with hemodynamic compromise). ICD-9 codes: 427.31, I48.0. Diagnosis Priority: Other. * **Hyperthyroidism:** This diagnosis was also documented multiple times. ICD-9 codes: 242.90, E05.90. Diagnosis Priority: Other. * **Rheumatoid Arthritis:** This was a recurring diagnosis throughout the stay. ICD-9 codes: 714.0, M06.9. Diagnosis Priority: Other. * **Hyponatremia:** Electrolyte imbalance was noted. ICD-9 codes: 276.1, E87.0, E87.1. Diagnosis Priority: Other. * **Leukocytosis:** White blood cell disorder was observed. ICD-9 codes: 288.8, D72.829. Diagnosis Priority: Other. * **Chronic Renal Insufficiency:** Renal disorder was a persistent concern. ICD-9 codes: 585.9, N18.9. Diagnosis Priority: Other.

Note that upon discharge, the patient remained with diagnoses of Rheumatoid Arthritis, Chronic Renal Insufficiency, and Atrial Fibrillation (with hemodynamic compromise).

4. Treatments:

The patient received various treatments, some of which were active upon discharge. The treatments included:

* **Cardiovascular Medications:** Digoxin, Metoprolol, Aspirin, Esmolol, and Diltiazem were administered at various times during the stay. The use of Metoprolol and Aspirin continued upon discharge. * **Electrolyte Correction:** Magnesium was administered throughout the stay, continuing at discharge. * **Fluid Administration:** Normal saline and D5 half-normal saline were administered. Normal saline continued at discharge. * **Bronchodilators:** Nebulized bronchodilators were administered, continuing at discharge. * **Cardiology Consultations:** Multiple cardiology consultations were documented. * **Sedative Agent:** Lorazepam was administered, continuing at discharge.

5. Vital Trends:

NULL (Insufficient data provided)

6. Lab Trends:

The provided lab data shows multiple blood tests taken at various times. The following trends are notable:

* **Hematological Parameters:** There are repeated measurements of Hemoglobin (Hgb), Hematocrit (Hct), Red Blood Cell count (RBC), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), Platelet count, White Blood Cell count (WBC), and differential counts (lymphocytes, monocytes, eosinophils, basophils, and polymorphonuclear leukocytes). These will be analyzed further in the visualizations section for potential trends and correlations. * **Chemistry Panel:** Serum electrolytes (sodium, potassium, chloride, bicarbonate, calcium, magnesium, anion gap), glucose, creatinine, albumin, total protein, total bilirubin, ALT (SGPT), AST (SGOT), total cholesterol, triglycerides, HDL, LDL, Ferritin, TIBC, Fe/TIBC Ratio, TSH, BNP, PT, PTT, and PT-INR were all measured. These chemistry values will also be visualized to track changes over time. * **ABG and Oxygenation:** FiO2 and LPM O2 were also documented.

7. Microbiology Tests:

NULL (Insufficient data provided)

8. Physical Examination Results:

Physical examinations were conducted, with the initial exam at 6 minutes post unit admission showing vital signs (HR, BP, RR, O2 Sat%), weight, and I&O.; A more detailed physical exam was conducted at 1046 minutes post unit admission which included: GCS score (15), irregular HR rhythm, weight, and I&O.; A subsequent note indicates that a physical exam was not performed at 1271 minutes post unit admission. The patient's appearance was noted as ill-appearing but well-developed and not in acute distress. The patient was oriented x3 with an appropriate affect.

Note: The exact dates and times are not included in the provided data, and therefore the report lacks precise timelines. The word “scored” in the physical exam section is non-specific and requires further clarification. The report also lacks detailed history information. More complete data is needed for a comprehensive analysis.