Medical Report - Patient 003-20281

1. Patient Information

* **Patient Unit Stay ID:** 264423 * **Unique Patient ID:** 003-20281 * **Gender:** Male * **Age:** 48 * **Ethnicity:** Native American * **Hospital Admission Time:** 2014, 10:42:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014, 16:35:00 * **Hospital Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014, 13:13:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2014, 16:35:00 * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive * **Admission Weight:** 103.5 kg * **Discharge Weight:** 103.2 kg * **Admission Height:** 165.1 cm

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon admission and active upon discharge was acute renal failure (ICD-9 codes: 584.9, N17.9). Another major diagnosis, active upon discharge, was congestive heart failure (ICD-9 codes: 428.0, I50.9). This diagnosis was recorded twice, once at 133 minutes and again at 251 minutes post unit admission. Type II diabetes mellitus was also diagnosed as an 'Other' diagnosis. Chronic kidney disease (ICD-9 codes: 585.9, N18.9) was also listed, but was not active upon discharge. Anemia was listed as another major diagnosis. The sequence of diagnoses in the data does not necessarily reflect the clinical presentation or severity. More detailed clinical information is needed to fully understand the patient's history and the relationships between these diagnoses.

4. Treatments

The patient received a range of treatments during their ICU stay. These included medications such as IV furosemide (intravenous diuretic), metoprolol (beta-blocker), omeprazole (stress ulcer prophylaxis), sodium bicarbonate (bicarbonate), and thiazides (oral diuretic), as well as metolazone (Zaroxolyn) (oral diuretic). Additionally, the patient received insulin via sliding scale administration, underwent a renal ultrasound and Nephrology consultation. A Foley catheter was also inserted. A transthoracic echocardiography was also performed.

5. Vital Trends

NULL (Insufficient data provided. Vital signs would need to be included in the dataset to generate this section.)

6. Lab Trends

The provided lab data includes a variety of blood tests and bedside glucose measurements taken at different times during the patient's stay. Several tests show evidence of kidney dysfunction, including elevated creatinine (5.1-5.2 mg/dL), BUN (53-59 mg/dL), and potassium (5.3-6.3 mmol/L), at various time points. Additionally, low hemoglobin and hematocrit levels (7.1-7.4 g/dL and 20.9-22.3%, respectively) are consistent with the anemia diagnosis. Blood glucose levels were consistently elevated (143-291 mg/dL) throughout the stay, reflecting the patient’s Type II diabetes. The data includes multiple bedside glucose measurements, suggesting frequent monitoring of the patient's blood sugar. More comprehensive analysis of the lab data would require plotting the values over time to identify trends and correlations.

7. Microbiology Tests

NULL (Insufficient data provided.)

8. Physical Examination Results

The physical exam documented the patient as obese and ill-appearing but not in acute distress. Vital signs recorded included a heart rate ranging from 83-87 bpm, a respiratory rate of 16-20 breaths per minute, blood pressure (systolic) consistently at 156 mmHg, and blood pressure (diastolic) consistently at 89 mmHg. Oxygen saturation was between 93-96%. The patient's GCS score was 15 (Eyes: 4, Verbal: 5, Motor: 6), indicating normal neurological function. The patient's LOC was normal and their affect was calm and appropriate. Orientation was unable to be assessed.