Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 453326 * **Unique Patient ID:** 005-10707 * **Gender:** Male * **Age:** 85 * **Ethnicity:** Hispanic * **Hospital ID:** 143 * **Ward ID:** 259 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 09:35:00 (2014) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 04:48:00 (2014) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 08:10:00 (2014) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 22:30:00 (2014) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height (cm):** 167.6 * **Admission Weight (kg):** 54.9 * **Discharge Weight (kg):** NULL

2. History

Admission diagnosis was CHF (Congestive Heart Failure). The patient presented to the Emergency Department via direct admit with symptoms consistent with worsening heart failure. The detailed history provided by family members and the patient (where possible) will be included in a separate, more detailed report. Further information regarding the patient's past medical history is required to complete this section adequately. Relevant details such as prior hospitalizations, surgeries, and significant medical conditions would enhance the understanding of the patient's current state. This section will be updated once additional information is available.

3. Diagnoses

* **Primary Diagnosis:** Congestive Heart Failure (428.0, I50.9) * cardiovascular|ventricular disorders|congestive heart failure * **Major Diagnosis:** Atrial Fibrillation with Rapid Ventricular Response (427.31, I48.0) * cardiovascular|arrhythmias|atrial fibrillation|with rapid ventricular response * **Other Diagnosis:** Hypertension (401.9, I10) * cardiovascular|ventricular disorders|hypertension

The diagnoses indicate a complex cardiovascular picture, with congestive heart failure as the primary concern, complicated by atrial fibrillation and pre-existing hypertension. The interplay of these conditions likely contributed to the patient’s need for ICU admission.

4. Treatments

* **Oxygen Therapy (40% to 60%):** Active upon discharge. * **Lisinopril (ACE inhibitor):** Active upon discharge. * **Pantoprazole (Stress Ulcer Prophylaxis):** Active upon discharge. * **Acetaminophen (Non-narcotic Analgesic):** Active upon discharge. * **Oral Analgesics:** Active upon discharge. * **Metoprolol (Beta Blocker):** Active upon discharge. * **Digoxin:** Active upon discharge. * **Thrombin Inhibitor (Anticoagulant):** Active upon discharge. * **IV Furosemide (Intravenous Diuretic):** Active upon discharge. * **Aspirin (Antiplatelet Agent):** Active upon discharge. * **Non-invasive Ventilation:** Active upon discharge.

The treatment plan reflects the multi-faceted nature of the patient’s condition, targeting heart failure, arrhythmia management, pain control, and prevention of complications such as stress ulcers. Further detail on the dosages and response to treatment is needed for a complete report.

5. Vital Trends

NULL. No vital signs data was provided.

6. Lab Trends

Several blood tests were performed, including complete blood count (CBC) with differential, basic metabolic panel (BMP), and cardiac biomarkers (troponin-I). The results show some abnormalities, notably elevated creatinine levels (1.2-1.4

mg/dL), suggesting renal impairment. The troponin-I levels were slightly elevated (0.06-0.07 ng/mL), possibly indicating some myocardial injury. The CBC reveals some abnormalities in the different cell counts, suggesting potential reasons for the diagnoses. A complete timeline of lab results is required for a thorough analysis of trends.

7. Microbiology Tests

NULL. No microbiology data was provided.

8. Physical Examination Results

The physical exam noted that the patient was ill-appearing. Vital signs on admission showed a heart rate of 92 bpm, blood pressure of 141/92 mmHg, respiratory rate of 19 breaths/minute, and oxygen saturation of 100% on 50% FiO2. The patient's heart rhythm was irregular with a narrow complex. The Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6), indicating normal neurological function. The patient was alert and oriented x3, with a calm and appropriate affect. The patient was not intubated. More detailed physical exam findings would improve the completeness of this section.