Medical Report for Patient 006-101284

1. Patient Information

* **Patient Unit Stay ID:** 576214 * **Unique Patient ID:** 006-101284 * **Gender:** Male * **Age:** 68 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 19:21:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 23:35:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 05:34:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 21:13:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Height (cm):** 188 * **Admission Weight (kg):** 99.4 * **Discharge Weight (kg):** NULL

2. History

Insufficient data provided to generate a detailed patient history. The report only includes admission and discharge times and locations, along with the patient's demographics. A complete history would require additional information such as presenting complaints, past medical history, family history, social history, and medication history. This information is crucial for understanding the context of the patient's ICU stay and subsequent diagnoses and treatments. Without this data, a comprehensive history section cannot be generated.

3. Diagnoses

* **Primary Diagnosis (Active upon Discharge):** Supraventricular Tachycardia (SVT) (ICD-9 codes: 427.0, I47.1) * **Primary Diagnosis (Inactive upon Discharge):** Supraventricular Tachycardia (SVT) (ICD-9 codes: 427.0, I47.1) * **Primary Diagnosis (Inactive upon Discharge):** Acute Myocardial Infarction (Non-ST Elevation) (ICD-9 codes: 410.71, I21.4) * **Primary Diagnosis (Inactive upon Discharge):** Acute Myocardial Infarction (Non-ST Elevation) (ICD-9 codes: 410.71, I21.4)

The patient presented with multiple cardiovascular diagnoses, with SVT being active upon discharge. The presence of non-ST elevation myocardial infarction suggests a history of cardiac ischemia. The temporal relationship between these diagnoses is unclear due to the lack of specific timeline information beyond the diagnosis offset times.

4. Treatments

NULL. No treatment information was provided in the dataset.

5. Vital Trends

The available physical examination data indicates vital signs recorded at multiple time points. However, without a precise timestamp for each measurement it's impossible to generate a true vital trend analysis. The data suggests a heart rate range of 55-71 bpm, a systolic blood pressure range of 84-105 mmHg, a diastolic blood pressure range of 38-73 mmHg, and a respiratory rate range of 12-21 breaths/min. Oxygen saturation was consistently around 93-94%. More frequent and time-stamped vital sign data is needed for a proper trend analysis.

6. Lab Trends

The provided lab data shows several blood tests performed at different times during the patient's stay. Again, the lack of precise time stamps makes it difficult to create a comprehensive trend analysis. The following labs were tested: MCH, BUN, MCV, glucose, Hgb, calcium, WBC x 1000, bicarbonate, platelets x 1000, PT, potassium, MCHC, PTT, RDW, lipase, total bilirubin, creatinine, AST (SGOT), TSH, chloride, ALT (SGPT), total protein, and PT-INR. Values vary considerably between the initial and follow-up tests performed. A time-series analysis is needed to determine the trends and significance of the changes in these lab values.

7. Microbiology Tests

NULL. No microbiology test results were provided.

8. Physical Examination Results

Physical examinations were performed at multiple times during the patient's stay. The information given includes heart rate (HR), blood pressure (BP), respiratory rate (RR), and oxygen saturation (SpO2). Recorded values suggest a stable, yet not entirely normal, cardiovascular and respiratory status. Again, more detailed and time-stamped data is required for a more accurate interpretation.