Medical Report: Patient 004-13109

1. Patient Information

* **Patient Unit Stay ID:** 336272 * **Unique Patient ID:** 004-13109 * **Gender:** Female * **Age:** 67 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 16:09:00 * **Hospital Discharge Time:** 2015-XX-XX 18:39:00 * **Unit Admit Time:** 2015-XX-XX 16:09:00 * **Unit Discharge Time:** 2015-XX-XX 19:36:00 * **Unit Type:** Med-Surg ICU * **Hospital Admit Source:** Emergency Department * **Unit Admit Source:** Emergency Department * **Hospital Discharge Location:** Home * **Unit Discharge Location:** Floor * **Admission Weight:** 64.9 kg * **Admission Height:** 162.5 cm * **Admission Diagnosis:** Chest pain, unknown origin

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnosis upon discharge was cardiovascular chest pain, r/o myocardial ischemia. Major diagnoses included gastrointestinal abdominal pain/tenderness (ICD-9: 789.00, R10.9) and cardiovascular atrial fibrillation with rapid ventricular response (ICD-9: 427.31, I48.0). Other diagnoses included known coronary artery disease (ICD-9: 414.00, I25.10), hypothyroidism (ICD-9: 244.9, E03.9), and Parkinson's disease (ICD-9: 332.0, G20). Several diagnoses were initially listed but later deemed inactive upon discharge. These included r/o myocardial ischemia, s/p exploratory laparotomy, and additional instances of abdominal pain, atrial fibrillation, and hypothyroidism.

4. Treatments

The patient received a comprehensive treatment regimen. Medications administered included Ondansetron (antiemetic), Pantoprazole (stress ulcer prophylaxis), and Lisinopril (ACE inhibitor). Further treatments included narcotic analgesics, simvastatin (HMG-CoA reductase inhibitor), amiodarone (class III antiarrhythmic), and aspirin (antiplatelet agent). Diagnostic procedures such as transthoracic echocardiography and chest x-rays were also performed. Supportive care involved oxygen therapy via nasal cannula and compression stockings for VTE prophylaxis. Oral feeds were provided for nutrition. Note that some treatments were initiated and later discontinued during the ICU stay.

5. Vital Trends

* **Heart Rate (HR):** Current, lowest, and highest values were all recorded as 149 bpm at the time of the physical exam. Further time-series data is needed to establish trends. * **Blood Pressure (BP):** Systolic BP was recorded as 134 mmHg (current, lowest, and highest values). Diastolic BP was recorded as 81 mmHg (current, lowest, and highest values). Further time-series data is needed to establish trends. * **Respiratory Rate (RR):** Current, lowest, and highest values were all 19 breaths per minute at the time of the physical exam. Further time-series data is needed to establish trends. * **Oxygen Saturation (SpO2):** Current, lowest, and highest values were all recorded as 99% at the time of the physical exam. Further time-series data is needed to establish trends. * **Glasgow Coma Scale (GCS):** A GCS score of 15 (Eyes 4, Verbal 5, Motor 6) was documented. Further time-series data is needed to establish trends.

6. Lab Trends

The following lab results were obtained 47 minutes post-unit admission:

* **Total Bilirubin:** 0.3 mg/dL * **BUN:** 22 mg/dL * **Hgb:** 13.2 g/dL * **Glucose:** 119 mg/dL * **WBC x 1000:** 7.3 K/mcL * **Creatinine:** 1.2 mg/dL * **Hct:** 42.2 % * **Sodium:** 140 mmol/L * **Albumin:** 4.0 g/dL

FiO2 was measured at 28% at 137 minutes post-unit admission. Further time-series data is needed to establish trends.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

A structured physical exam was performed 49 minutes post-unit admission. Vital signs recorded include HR 149 bpm, BP 134/81 mmHg, RR 19 breaths/min, SpO2 99%, and admission weight 64.9 kg. The patient's respiratory mode was spontaneous. A GCS of 15 was documented (Eyes 4, Verbal 5, Motor 6).