Medical Report for Patient 004-12627

1. Patient Information:

* **Patient Unit Stay ID:** 332296 * **Unique Patient ID:** 004-12627 * **Gender:** Male * **Age:** 40 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 16:45:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015, 16:30:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015, 22:26:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015, 16:30:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Weight:** 93.6 kg * **Admission Height:** 198.1 cm

2. History:

The patient was admitted to the hospital via the Emergency Department with a primary diagnosis of Diabetic Ketoacidosis (DKA). The patient presented with symptoms consistent with DKA, including hyperglycemia. A detailed history of the patient's symptoms leading up to admission is not available in the provided data. Further information regarding the patient's medical history prior to this ICU stay is needed to provide a complete history. The patient's admission to the Med-Surg ICU was prompted by the severity of their DKA requiring intensive care management. The patient's overall history is incomplete without additional context. The duration of symptoms before presentation to the hospital needs clarification, as does the patient's past medical history, including any known diabetes or other relevant conditions. Family history and social history information would also greatly enhance the understanding of the patient's condition and risk factors. The lack of information hinders the ability to provide a comprehensive history section.

3. Diagnoses:

* **Primary:** Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) * **Major:** Hyperglycemia (ICD-9 codes: 790.6, R73.9) * **Major:** Diabetes Mellitus (ICD-9 code: Not specified)

All diagnoses were active upon discharge from the unit. The diagnoses were recorded 25 minutes after unit admission time. The absence of a detailed ICD-9 code for diabetes mellitus limits the precision of the diagnosis. Further investigation into the specifics of the diabetes diagnosis is warranted. The relationship between the diagnoses (DKA, hyperglycemia, and diabetes mellitus) is evident, indicating a clear progression or manifestation of the underlying diabetic condition. The lack of further diagnostic information (e.g., blood glucose levels, electrolyte panels) prevents further detailed analysis.

4. Treatments:

* **Endocrine/Glucose Metabolism:** Continuous insulin infusion * **Endocrine/Glucose Metabolism:** Sliding scale insulin administration * **Cardiovascular/Hypertension:** Lisinopril (ACE inhibitor) * **Gastrointestinal/Medications:** Serotonin antagonist (antiemetic)

All treatments were active upon discharge. The treatments are consistent with the management of DKA and associated symptoms. The specific dosages and response to these treatments are not included in the data, which prevents a complete evaluation of their effectiveness. Additional information regarding medication administration, titration, and patient response is crucial. The duration of each treatment and their individual contributions to the patient's recovery require further explanation.

5. Vital Trends: NULL

6. Lab Trends: NULL

7. Microbiology Tests: NULL

8. Physical Examination Results:

* **Weight (kg):** 93.6 (Admission weight) * **Heart Rate (HR):** 109 bpm * **Blood Pressure (BP):** 159/100 mmHg * **Respiratory Rate:** 22 breaths/minute * **Oxygen Saturation (SpO2):** 99% * **FiO2:** 21% * **Glasgow Coma Scale (GCS):** 15 (Eyes: 4, Verbal: 5, Motor: 6)

The physical exam was performed and documented 14 minutes after unit admission. The GCS score indicates a normal level of consciousness. However, the absence of serial vital signs measurements and other physical examination findings prevents an assessment of the patient's physiological trends during the ICU stay. Additional data, such as daily or hourly measurements of vital signs and other relevant parameters are required for a more comprehensive analysis.

Conclusion: This report provides a partial overview of the patient's ICU stay based on the limited data provided. Significant gaps exist in the patient's history, lab results, vital signs trends, and detailed treatment information. Further information is necessary to create a complete and accurate medical report.