

****Patient Medical Report****

****1. Patient Information****

* **Patient Unit Stay ID:** 350259 * **Patient Health System Stay ID:** 301125 * **Unique Patient ID:** 004-11402 *
* **Gender:** Male * **Age:** 88 * **Ethnicity:** Caucasian * **Hospital ID:** 133 * **Ward ID:** 176 * **Unit Type:**
Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 20:15:00 (Assuming a date is present in the original data but missing
from the provided JSON) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX
17:59:00 (Assuming a date is present in the original data but missing from the provided JSON) * **Unit Discharge
Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 67.5 kg * **Discharge Weight:** NULL (Not
provided) * **Admission Height:** 162.5 cm * **APACHE Admission Diagnosis:** CHF, congestive heart failure * **Hospital
Admit Time:** 2015-XX-XX 16:17:00 (Assuming a date is present in the original data but missing from the provided JSON)
* **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:**
2015-XX-XX 01:15:00 (Assuming a date is present in the original data but missing from the provided JSON) * **Hospital
Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive

****2. History****

The patient's history is not explicitly detailed in the provided data. The APACHE admission diagnosis indicates a history of congestive heart failure (CHF). Further information on past medical history, family history, and social history is required for a comprehensive history section. NULL.

****3. Diagnoses****

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was Congestive Heart Failure (CHF) (ICD-9 codes: 428.0, I50.9). Other significant diagnoses included:

* Altered mental status and depression (ICD-9 codes: 311, F32.9) * Chest pain (ICD-9 codes: 786.50, R07.9) * Suicidal ideation (ICD-9 codes: V62.84, R45.851) * Abdominal pain/tenderness (ICD-9 codes: 789.00, R10.9)

The temporal relationships between these diagnoses are indicated by the `diagnosisOffset` field, showing which diagnoses were recorded at what time relative to admission. Note that some diagnoses were active upon discharge while others were not. The `diagnosisPriority` field indicates the relative clinical significance of each diagnosis.

****4. Treatments****

The patient received a range of treatments during their ICU stay, including:

* **Cardiovascular:** Anticoagulant administration (Enoxaparin), analgesics (bolus parenteral and narcotic), nitroglycerin (sublingual), aspirin, IV furosemide. * **Gastrointestinal:** Stress ulcer prophylaxis (Pantoprazole), oral feeds. *
* **Pulmonary:** Oxygen therapy (25-30% and nasal cannula). * **Psychiatric:** Suicide precautions and psychiatry consultation.

The `activeUpondischarge` field shows which treatments were ongoing at the time of unit discharge.

****5. Vital Trends****

Based on the physical examination, the following vital signs were recorded:

* **Heart Rate (HR):** Current: 121 bpm, Lowest: 112 bpm, Highest: 124 bpm * **Respiratory Rate (RR):** Current: 23 breaths/min, Lowest: 22 breaths/min, Highest: 33 breaths/min * **Oxygen Saturation (O2 Sat):** Current: 96%, Lowest: 94%, Highest: 97% * **Blood Pressure (BP):** Systolic: 117 mmHg, Diastolic: 74 mmHg * **Glasgow Coma Scale

(GCS):** Total Score: 15 (4+5+6)

Note: This is a snapshot of vital signs at one point in time. A complete trend analysis requires a time series of vital signs data. NULL.

6. Lab Trends

The available lab data includes:

* **Troponin-I:** 0.37 ng/mL * **CPK-MB Index:** 3 % * **CPK-MB:** 3 ng/mL * **Glucose:** 176 mg/dL * **WBC x 1000:** 82.2 K/mcL * **BUN:** 47 mg/dL

The `labResultOffset` field indicates the time each lab value was drawn. More comprehensive lab data, including repeated measurements over time, are needed for a trend analysis. NULL.

7. Microbiology Tests

NULL. No microbiology test results are provided in the data.

8. Physical Examination Results

The physical examination notes include vital signs (HR, RR, O2 Sat, BP) and a GCS score of 15. More detailed physical examination findings are needed for a complete report. The available data represents only a partial physical examination.