Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 380316 * **Patient Health System Stay ID:** 325848 * **Gender:** Female * **Age:** 39 * **Ethnicity:** Caucasian * **Hospital ID:** 125 * **Ward ID:** 174 * **Admission Diagnosis:** Overdose, other toxin, poison or drug * **Admission Height:** 167.6 cm * **Hospital Admit Time:** 2015-MM-DD 20:18:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-MM-DD 15:28:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-MM-DD 23:51:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 71.21 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 2015-MM-DD 15:50:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-11155

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, reflecting the complexity of her case. The primary diagnosis upon admission and at discharge was drug overdose (toxicology|drug overdose|drug overdose- general). This was further complicated by major diagnoses including seizures (neurologic|seizures|seizures), hypokalemia (renal|electrolyte imbalance|hypokalemia), and abdominal pain/tenderness (gastrointestinal|abdominal/ general|abdominal pain / tenderness), nausea with vomiting (gastrointestinal|abdominal/ general|nausea|with vomiting), cholecystitis (gastrointestinal|biliary disease|cholecystitis), and cholelithiasis (gastrointestinal|biliary disease|biliary obstruction|cholelithiasis). The multiplicity of diagnoses suggests a potentially severe and multi-systemic presentation. Note that some diagnoses lacked ICD-9 codes, indicating potential data entry inconsistencies or incomplete record-keeping. The timing of diagnosis entry, as indicated by `diagnosisoffset`, shows that many diagnoses were entered concurrently, around 1026 minutes post-unit admission. However, some diagnoses were recorded significantly earlier (783-784 minutes). This may reflect the evolving understanding of the patient's condition as her stay progressed.

4. Treatments

The patient received a broad range of treatments addressing her various diagnoses. These included multiple CT scans (gastrointestinal|radiology, diagnostic and procedures|CT scan|pelvis, gastrointestinal|radiology, diagnostic and procedures|CT scan|abdomen), intravenous fluid administration (gastrointestinal|intravenous fluid administration|normal saline administration), oral and non-narcotic analgesics (gastrointestinal|medications|analgesics|oral analgesics, gastrointestinal|medications|analgesics|non-narcotic analgesic), ondansetron (gastrointestinal|medications|antiemetic|serotonin antagonist|ondansetron), lorazepam (neurologic|pain / agitation / altered mentation|sedative agent|lorazepam), potassium administration (renal|electrolyte correction|electrolyte administration|potassium), and compression stockings (pulmonary|vascular disorders|VTE prophylaxis|compression stockings). The administration of potassium suggests a focus on correcting her hypokalemia. The multiple analgesic medications address her abdominal pain. The fact that some treatments were active upon discharge highlights the ongoing management of her conditions. Furthermore, the relatively high number of treatments underscores the severity of her presentation and the need for comprehensive care.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

The lab results show some key trends. There are repeated measurements of several lab values, including electrolytes, liver function tests, and complete blood count. Potassium levels were initially low (2.9 mmol/L) but improved (4.3 mmol/L)

at a later timepoint. Phenytoin levels were monitored multiple times, indicating the potential for anticonvulsant therapy. The complete blood count (CBC) revealed elevated white blood cells. Further analysis would be required to fully interpret these lab trends in the context of the patient's clinical presentation and overall management.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

A structured physical exam was performed, with vital signs recorded. The Glasgow Coma Scale (GCS) was documented as 15 (Eyes 4, Verbal 5, Motor 6), suggesting a normal neurological exam. Heart rate was recorded between 65 and 72 bpm, and blood pressure between 132/102 and 149/115 mmHg. Oxygen saturation was consistently 100%, and admission weight was 71.21 kg. The documentation of both current and lowest/highest values for vital signs provides a more comprehensive picture of the patient's hemodynamic status during the exam.