Medical Report: Patient 007-10005

1. Patient Information

* **Patient Unit Stay ID:** 969334 * **Patient Health System Stay ID:** 714079 * **Unique Patient ID:** 007-10005 * **Gender:** Female * **Age:** 53 * **Ethnicity:** Caucasian * **Hospital ID:** 182 * **Ward ID:** 424 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 21:42:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 14:38:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2015-XX-XX 19:54:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 20:18:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 62.7 kg * **Discharge Weight:** 63.5 kg * **Admission Height:** 172.7 cm * **APACHE Admission Dx:** Overdose, analgesic (aspirin, acetaminophen)

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple drug overdoses. Specifically, the diagnoses included:

* **Toxicology|Drug overdose|Acetaminophen overdose:** ICD-9 codes E980.0, 965.4, T39.1X. This diagnosis was active upon discharge from the unit. * **Toxicology|Drug overdose|Narcotic overdose:** ICD-9 codes E980.2, 965.00, T40.60. This diagnosis was also active upon discharge from the unit.

Both acetaminophen and narcotic overdoses were initially recorded within the first 5 minutes of the unit admission. Additional entries for both overdoses were made later in the stay, but these subsequent entries were marked as inactive upon discharge. All diagnoses were classified as 'Other' priority. More detailed information regarding the circumstances surrounding the overdoses would be beneficial for a complete clinical picture.

4. Treatments

The patient received the following treatments during their ICU stay:

* **Neurologic|Pain / agitation / altered mentation|Antidepressant:** This treatment was active upon discharge. The specific antidepressant medication is not specified. * **Toxicology|Drug overdose|Normal saline solution:** This was administered early in the stay but was not active upon discharge. The volume and rate of administration are not specified. * **Toxicology|Drug overdose|Agent specific therapy|Acetaminophen overdose|N-acetylcysteine:** This treatment for acetaminophen overdose, involving N-acetylcysteine, was active upon discharge. Dosage and administration details are missing. * **Cardiovascular|Hypertension|Antihypertensive combination agent:** This treatment was active upon discharge from the unit, but the specific medication(s) are unspecified. * **Pulmonary|Consultations|Pulmonary/CCM consultation:** A pulmonary/CCM consultation was performed, but the details and outcomes are not available in the provided data. * **Gastrointestinal|Medications|Stress ulcer prophylaxis:** Stress ulcer prophylaxis was administered and was active upon discharge. The medication used for prophylaxis is not specified. * **Neurologic|Consultations|Psychiatry consultation:** A psychiatry consultation was performed, but further details are absent. * **Transplant|Consultations|Transplant surgery consultation:** A transplant surgery consultation was conducted, and this was active upon discharge. The reason for the consultation is not provided.

More detailed information on treatment administration (dosage, routes, times) is needed for a comprehensive report.

5. Vital Trends

NULL (Insufficient data to generate vital trends)

6. Lab Trends

The patient underwent multiple blood tests during their ICU stay. Significant findings included elevated liver enzymes (AST and ALT), and an initially elevated total bilirubin, which trended upward throughout the hospital stay. Other lab values were consistent with metabolic abnormalities. More information on the trends of these and other lab values over time would enhance the report.

7. Microbiology Tests

NULL (No microbiology test data provided)

8. Physical Examination Results

A structured physical exam was performed. The Glasgow Coma Scale (GCS) score was documented as 15 (Eyes 4, Verbal 5, Motor 6) at one point during the stay. Heart rate, blood pressure, respiratory rate, and oxygen saturation were also recorded at one time point. A more complete record of physical exam findings over time would be beneficial for a comprehensive report. Weight was monitored and showed a small increase during the stay. Fluid intake was recorded as 100ml, with 0ml of output, resulting in a net positive fluid balance.