Patient Information

Patient Unit Stay ID: 387984 Unique Patient ID: 004-12197 Gender: Female Age: 74 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 17:59:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2015-XX-XX 20:15:00 Hospital Discharge Location: Rehabilitation Unit Type: Med-Surg ICU Unit Admit Time: 2015-XX-XX 20:07:00 Unit Admit Source: Emergency Department Unit Discharge Time: 2015-XX-XX 20:15:00 Unit Discharge Location: Rehabilitation Admission Weight: 101.5 kg Discharge Weight: NULL Admission Height: 160 cm APACHE Admission Diagnosis: CVA, cerebrovascular accident/stroke

Medical History

NULL (No detailed medical history provided in the input data.)

Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others resolved during the ICU stay. The primary diagnosis throughout the stay was stroke (ICD-9 codes 436, I67.8). Major diagnoses included hypertension (ICD-9 codes 401.9, I10), urinary tract infection (ICD-9 codes 599.0, N39.0), congestive heart failure (ICD-9 codes 428.0, I50.9), atrial fibrillation (ICD-9 codes 427.31, I48.0), and hypothyroidism (ICD-9 codes 244.9, E03.9). The stroke diagnosis was recorded multiple times, indicating potential reassessments or changes in its presentation during the ICU stay. The timestamps associated with the diagnosis entries show that several diagnoses were established early in the stay (around 537 minutes post-admission), while others were added later (around 1318 minutes post-admission), suggesting an evolving clinical picture.

Treatments

The patient received a comprehensive range of treatments. These included medications such as ondansetron (antiemetic), ciprofloxacin (antibacterial), enoxaparin (low molecular weight heparin), pravastatin (antihyperlipidemic), and levothyroxine (thyroid hormone). Various diagnostic tests were performed including head CT scans, MRI of the head, and transthoracic echocardiography. The patient also received VTE prophylaxis with compression boots and stockings. The use of a Foley catheter and enteral feeds (oral feeds) are also documented. Note that there are multiple entries for some treatments, indicating either repeated administration or different times of entry into the system. The timing of treatments, both early and late in the stay, suggests a dynamic approach to management, reflecting the complexity of the patient's condition and the evolving nature of her diagnoses.

Vital Trends

NULL (No vital signs data provided in the input data.)

Lab Trends

The available laboratory data is limited to a single time point (approximately 39-44 minutes post-admission). The results show:

* Glucose: 109 mg/dL * Chloride: 106 mmol/L * Albumin: 2.8 g/dL * Creatinine: 2.2 mg/dL * Hematocrit (Hct): 37.3% * Hemoglobin (Hgb): 11.1 g/dL * Platelets: 216 K/mcL * WBC: 7.3 K/mcL * Potassium: 3.9 mmol/L * Sodium: 144 mmol/L * FiO2: 28%

Further lab data would be needed to assess trends over time.

Microbiology Tests

Blood, urine, and stool cultures were ordered. The results are not included in the provided data.

Physical Examination Results

A structured physical exam was performed at approximately 17 minutes post-admission. The recorded vital signs are: respiratory rate 21 breaths/min, heart rate 75 beats/min, systolic blood pressure 164 mmHg, diastolic blood pressure 95 mmHg, and oxygen saturation 100%. The Glasgow Coma Scale (GCS) was scored as 13 (E=4, V=4, M=5), indicating a moderate level of consciousness. FiO2 was 28%.