Patient Information

Patient Unit Stay ID: 849186 Unique Patient ID: 006-101740 Gender: Male Age: 76 Ethnicity: Caucasian Hospital Admit Time: 2014-XX-XX 02:03:00 Hospital Admit Source: Emergency Department Unit Type: Med-Surg ICU Unit Admit Time: 2014-XX-XX 23:22:00 Unit Admit Source: Other ICU Unit Discharge Time: 2014-XX-XX 21:22:00 Unit Discharge Location: Step-Down Unit (SDU) Admission Weight: 68.2 kg Discharge Weight: NULL Admission Height: 172.7 cm

Medical History

Insufficient information provided to generate a detailed medical history. The provided data only includes diagnoses and treatments, lacking details on past medical conditions, surgeries, allergies, family history, or social history. Further information is needed to complete this section.

Diagnoses

The patient presented with the following diagnoses during their ICU stay:

* **Primary Diagnosis:** Pulmonary|Respiratory Failure|Acute Respiratory Distress Syndrome (ARDS) (ICD-9 code: 518.82). This diagnosis was active upon discharge from the unit. * **Major Diagnosis:** Cardiovascular|Shock / Hypotension|Sepsis|Severe (ICD-9 code: 995.92, R65.2). This diagnosis was not active upon discharge from the unit.

Both the primary and major diagnoses were entered 13 minutes after unit admission. Additional instances of both diagnoses were also recorded at 894 minutes post-admission. The sepsis diagnosis remained active upon discharge from the unit.

Treatments

The patient received the following treatment:

* **Pulmonary|Ventilation and Oxygenation|Non-invasive Ventilation:** This treatment was initiated 13 minutes after unit admission and was not active upon discharge. This suggests the patient required respiratory support initially but was successfully weaned off before leaving the ICU.

Vital Trends

NULL. No vital sign data is available in the provided dataset.

Lab Trends

The following laboratory results were recorded:

* **Hematology:** MCV (95 fL), Hgb (13.9 g/dL), MPV (10.3 fL), RBC (4.22 M/mcL), Hct (40.2%), Platelets (134 K/mcL), MCH (32.9 pg), MCHC (34.6 g/dL), WBC (8.7 K/mcL) were measured at 628 minutes post-admission. These values provide a snapshot of the patient's blood composition at a single point in time. More frequent measurements would be needed to analyze trends. * **Chemistry:** Anion gap (4), Sodium (136 mmol/L), Phosphate (2.8 mg/dL), Chloride (99 mmol/L), Bicarbonate (33 mmol/L), Calcium (9.0 mg/dL), Potassium (4.3 mmol/L), BUN (37 mg/dL) were recorded at 666 minutes post admission. These results again offer a single point in time and lack trend data. * **Miscellaneous:** Bedside glucose (185 mg/dL) was recorded at 251 minutes post admission and represents a single measurement at this point in the hospital stay. * **Arterial Blood Gas (ABG):** FiO2 (35%) was recorded at 14 minutes post admission and represents a single measurement.

More frequent lab results would be necessary to identify trends and assess the patient's response to treatment over time.

Microbiology Tests

NULL. No microbiology test data is included in the provided dataset.

Physical Examination Results

The physical examination recorded the following:

* Glasgow Coma Scale (GCS) score: 15 (Eyes 4, Verbal 5, Motor 6), indicating a normal level of consciousness at the time of the exam (9 minutes post-admission). * Heart Rate: Current 116 bpm, Lowest 94 bpm, Highest 136 bpm. * Blood Pressure (systolic): Current 144 mmHg, Lowest 144 mmHg, Highest 198 mmHg. * Blood Pressure (diastolic): Current 90 mmHg, Lowest 90 mmHg, Highest 110 mmHg. * Weight: Admission weight 68.2 kg, Current weight 77.9 kg, Delta +9.7 kg. This shows significant weight gain during the ICU stay. * Intake and Output: Urine output 870 ml, Total intake 1720 ml, Total output 876 ml, Net fluid balance +844 ml. This suggests a positive fluid balance, which might be related to the patient's condition.

The physical exam indicates that the patient had normal neurologic function at one point in time and a positive fluid balance. More frequent physical exam data would be needed to understand trends.