

## **\*\*Medical Report for Patient 004-15711\*\***

### **\*\*1. Patient Information\*\***

**\*\*Patient Unit Stay ID:\*\*** 350437 **\*\*Unique Patient ID:\*\*** 004-15711 **\*\*Gender:\*\*** Male **\*\*Age:\*\*** 34 **\*\*Ethnicity:\*\*** Caucasian **\*\*Hospital Admit Time:\*\*** 2014-03-03 03:33:00 **\*\*Hospital Discharge Time:\*\*** 2014-03-04 16:34:00 **\*\*Unit Admit Time:\*\*** 2014-03-03 03:52:00 **\*\*Unit Discharge Time:\*\*** 2014-03-04 17:46:00 **\*\*Unit Type:\*\*** Med-Surg ICU **\*\*Admission Weight:\*\*** 85.9 kg **\*\*Admission Height:\*\*** 175.3 cm **\*\*Hospital Admit Source:\*\*** Emergency Department **\*\*Unit Admit Source:\*\*** Emergency Department **\*\*Hospital Discharge Location:\*\*** Home **\*\*Unit Discharge Location:\*\*** Floor **\*\*Hospital Discharge Status:\*\*** Alive **\*\*Unit Discharge Status:\*\*** Alive

### **\*\*2. History\*\***

Admission diagnosis was upper GI bleeding. The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU. Further details regarding the patient's history prior to admission are not available in the provided data.

### **\*\*3. Diagnoses\*\***

**\*\*Primary Diagnosis:\*\*** Upper GI bleeding (578.9, K92.2) \* Gastrointestinal | GI bleeding / PUD | upper GI bleeding \* Active upon discharge: False \* Diagnosis entered 149 minutes after unit admission **\*\*Primary Diagnosis:\*\*** Upper GI bleeding (578.9, K92.2) \* Gastrointestinal | GI bleeding / PUD | upper GI bleeding \* Active upon discharge: True \* Diagnosis entered 512 minutes after unit admission **\*\*Other Diagnosis:\*\*** Hypertension (401.9, I10) \* Cardiovascular | vascular disorders | hypertension \* Active upon discharge: True \* Diagnosis entered 512 minutes after unit admission

### **\*\*4. Treatments\*\***

The patient received the following treatments during their ICU stay:

**\*\*Ondansetron (IV):\*\*** Antiemetic, serotonin antagonist. Active upon discharge: False; Started 149 minutes post-admission; Stopped prior to discharge. **\*\*Pantoprazole (IV):\*\*** Stress ulcer treatment. Active upon discharge: True; Started 149 minutes post-admission; Continued post-discharge. **\*\*Amoxicillin (IV):\*\*** Therapeutic antibacterial, penicillin. Active upon discharge: True; Started 512 minutes post-admission; Continued post-discharge. **\*\*Normal Saline Administration (Moderate Volume Resuscitation):\*\*** Intravenous fluid administration. Active upon discharge: True; Started 149 minutes post-admission; Continued post-discharge. **\*\*Clarithromycin (IV):\*\*** Therapeutic antibacterial, macrolide. Active upon discharge: True; Started 512 minutes post-admission; Continued post-discharge.

### **\*\*5. Vital Trends\*\***

**\*\*Heart Rate (HR):\*\*** Current 68 bpm, Lowest 65 bpm, Highest 68 bpm. **\*\*Blood Pressure (BP):\*\*** Systolic: Current 132 mmHg, Lowest 132 mmHg, Highest 156 mmHg. Diastolic: Current 76 mmHg, Lowest 76 mmHg, Highest 81 mmHg. **\*\*Respiratory Rate (RR):\*\*** Current 20 breaths/min, Lowest 20 breaths/min, Highest 21 breaths/min. **\*\*Oxygen Saturation (O2 Sat):\*\*** Current 94%, Lowest 92%, Highest 95%. Respiration Mode: Spontaneous.

### **\*\*6. Lab Trends\*\***

The following lab results are available:

**\*\*BUN:\*\*** 17 mg/dL (drawn 119 minutes post-admission) **\*\*Albumin:\*\*** 5.1 g/dL (drawn 119 minutes post-admission) **\*\*Glucose:\*\*** 102 mg/dL (drawn 119 minutes post-admission) **\*\*Total Bilirubin:\*\*** 0.9 mg/dL (drawn 119 minutes post-admission) **\*\*Creatinine:\*\*** 1.0 mg/dL (drawn 119 minutes post-admission) **\*\*Sodium:\*\*** 141 mEq/L (drawn 119 minutes post-admission) **\*\*WBC x 1000:\*\*** 17.8 K/mcL (drawn 124 minutes post-admission) **\*\*Hct:\*\*** 55.7% (drawn 124 minutes post-admission)

#### **\*\*7. Microbiology Tests\*\***

NULL

#### **\*\*8. Physical Examination Results\*\***

A structured physical exam was performed 109 minutes after unit admission. The Glasgow Coma Scale (GCS) was 15 (Eyes 4, Verbal 5, Motor 6).

This report is based on the provided data. More comprehensive information may be available in the complete patient record. Further analysis is needed to completely understand the patient's condition. The short time frame and limited lab data prevent a detailed trend analysis.