Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 382892 * **Patient Health System Stay ID:** 327947 * **Gender:** Female * **Age:** 34 * **Ethnicity:** NULL * **Hospital ID:** 123 * **Ward ID:** 175 * **Admission Diagnosis:** Overdose, sedatives, hypnotics, antipsychotics, benzodiazepines * **Admission Height (cm):** 154.9 * **Hospital Admit Time:** 2015-XX-XX 21:42:00 (Hospital offset: -158 minutes from unit admit) * **Hospital Admit Source:** NULL * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 19:32:00 (Hospital offset: 2592 minutes from unit admit) * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 00:20:00 * **Unit Admit Source:** ICU to SDU * **Unit Visit Number:** 2 * **Unit Stay Type:** stepdown/other * **Admission Weight (kg):** NULL * **Discharge Weight (kg):** NULL * **Unit Discharge Time:** 2015-XX-XX 19:32:00 (Unit offset: 2592 minutes from unit admit) * **Unit Discharge Location:** Rehabilitation * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-15805

2. History

Insufficient data provided to generate a detailed patient history. The available data only indicates the patient was admitted to the Med-Surg ICU from another ICU, suggesting a transfer after an initial critical care period. The admission diagnosis points towards a drug overdose involving sedatives, hypnotics, antipsychotics, and benzodiazepines. Further details regarding the events leading to admission are lacking. More information is needed to reconstruct a complete patient history, including prior medical conditions, family history, social history, and detailed timeline of events surrounding the overdose. The absence of a detailed history necessitates a more comprehensive record review to provide a thorough account. The limited information suggests a complex case necessitating a deeper exploration of the patient's background to fully understand the present condition and inform future care.

3. Diagnoses

* **Diagnosis 1 (Primary):** toxicology|drug overdose|drug overdose- general|suicide attempt (ICD-9: NULL) * **Diagnosis 2 (Other):** toxicology|drug overdose|benzodiazepine overdose (ICD-9: 969.4, E980.2, T42.4X) * **Diagnosis 3 (Other):** neurologic|altered mental status / pain|depression (ICD-9: 311, F32.9)

Each diagnosis is linked to the patient's unit stay (patientunitstayid: 382892). The primary diagnosis points to a drug overdose with possible suicidal intent. The secondary diagnoses indicate benzodiazepine overdose and a comorbid depression and altered mental status, suggesting a complex clinical picture. The ICD-9 codes offer further specificity but lack complete information for the primary diagnosis. Further investigation into the patient's medical records is required to fully understand the clinical presentation and the interplay between these diagnoses. The lack of complete ICD-9 codes is concerning and needs to be addressed. This gap in data is likely due to incomplete chart documentation or coding errors which should be addressed to ensure data integrity and accurate medical record keeping.

4. Treatments

NULL. No treatment information is available in the provided dataset.

5. Vital Trends

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

6. Lab Trends

NULL. No laboratory data is available in the provided dataset.

7. Microbiology Tests

NULL. No microbiology test results are available in the provided dataset.

8. Physical Examination Results

* **Admission Weight:** 66.2 kg * **Respiratory Mode:** Spontaneous * **Glasgow Coma Scale (GCS):** 15 (Eyes: 4, Verbal: 5, Motor: 6) * **Physical Exam Performed:** A complete physical exam was not performed. The provided data only includes a partial GCS and admission weight. A full physical exam is needed to evaluate the patient's condition thoroughly. The limited data available does not permit a full assessment of the patient's physical status.

The documentation of the physical examination is incomplete. The lack of a comprehensive physical exam record hinders the ability to fully assess the patient's condition. This necessitates a review of the complete physical examination records to understand the patient's baseline physical condition and to track any changes that may have occurred during the ICU stay. The information available is insufficient for a complete physical exam review. This indicates that there may be gaps in the documentation process which should be addressed to ensure a complete patient record.