Medical Report for Patient 006-100471

1. Patient Information:

* **Patient Unit Stay ID:** 542874 * **Unique Patient ID:** 006-100471 * **Gender:** Female * **Age:** 41 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2014-XX-XX 02:52:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 20:52:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 05:28:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 20:52:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Weight (kg):** 90 * **Discharge Weight (kg):** 92.5 * **Admission Height (cm):** 167

2. History:

Admission diagnosis was respiratory arrest (without cardiac arrest). 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 unavailable in the provided data. A more complete history would be necessary for a comprehensive assessment.

3. Diagnoses:

* **Primary Diagnosis:** Pulmonary, Respiratory Failure, Acute Respiratory Failure (ICD-9 codes: 518.81, J96.00) * **Major Diagnosis:** Pulmonary, Respiratory Failure, Acute Respiratory Failure due to volume overload without CHF (ICD-9 codes: 518.81, J96.00)

Both diagnoses indicate acute respiratory failure, with the second suggesting a potential contributing factor of volume overload. The lack of information on the patient's medical history prior to admission limits the understanding of the underlying causes of this respiratory failure. Additional information, such as imaging results (chest x-ray, CT scan), would be beneficial in further elucidating the etiology.

4. Treatments:

* **Mechanical Ventilation:** The patient was placed on mechanical ventilation, which was active upon discharge from the unit. Details regarding ventilator settings, respiratory support parameters, and weaning strategies are not included in the dataset and would be essential for a complete treatment overview.

5. Vital Trends:

NULL. The provided data lacks time-series data on vital signs (heart rate, respiratory rate, blood pressure, oxygen saturation) that would allow for the creation of vital sign trends over the course of the ICU stay. This information is crucial for assessing the patient's clinical course and response to treatment.

6. Lab Trends:

NULL. While the dataset contains laboratory results, it does not provide the necessary timestamps to create meaningful lab trends. Time-series data is essential to track changes in various lab parameters and assess their correlation with the patient's clinical status. The inclusion of dates and times for each lab test is vital for analysis.

7. Microbiology Tests:

NULL. The provided data does not contain any information on microbiology tests performed during the patient's stay. Such information (e.g., blood cultures, sputum cultures) would be vital in identifying potential infections and guiding appropriate antimicrobial therapy.

8. Physical Examination Results:

* **Physical Exam Performed:** A structured physical exam was performed at 16 minutes post-unit admission. * **Heart Rate (Current, Lowest, Highest):** 118 bpm * **Blood Pressure (Systolic - Current, Lowest, Highest):** 119/47 mmHg (Highest systolic 133 mmHg) * **Respiratory Rate (Current, Lowest, Highest):** 18 breaths/min * **Oxygen Saturation (Current, Lowest, Highest):** 100% * **Weight (Admission, Current, Delta):** 90 kg (Current weight also 90 kg, no change) * **I&O; (Intake, Output, Dialysis Net, Total Net):** 0 ml * **Glasgow Coma Scale (GCS) Score:** 15 (Eyes 4, Verbal 5, Motor 6)

The physical exam findings at admission suggest a patient with stable vital signs. However, a comprehensive physical examination report is needed to evaluate other organ systems and provide a complete picture of the patient's condition.

Note: This report is limited by the incompleteness of the provided data. A complete medical record with additional information, including details regarding the patient's history, vital signs trends, comprehensive laboratory data, microbiology results, and detailed physical examination notes, would provide a significantly more thorough and informative report.