\*\*Medical Report for Patient 004-10675\*\*

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

\* \*\*Patient Unit Stay ID:\*\* 342371 \* \*\*Unique Patient ID:\*\* 004-10675 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 21 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital Admission Time:\*\* 2015, 14:48:00 \* \*\*Hospital Admission Source:\*\* Operating Room \* \*\*Hospital Discharge Time:\*\* 2015, 15:30:00 \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admission Time:\*\* 2015, 22:26:00 \* \*\*Unit Admission Source:\*\* Operating Room \* \*\*Unit Discharge Time:\*\* 2015, 18:00:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Admission Weight:\*\* 86.1 kg \* \*\*Admission Height:\*\* 167.1 cm

\*\*2. History\*\*

The patient was admitted to the hospital from the Operating Room following an appendectomy. The admission diagnosis was "Appendectomy". The patient was subsequently transferred to the Med-Surg ICU. The duration of the ICU stay was approximately 1174 minutes (19.57 hours).

\*\*3. Diagnoses\*\*

The patient presented with multiple diagnoses, all active upon discharge:

\* \*\*Primary:\*\* \* Acute appendicitis with perforation (ICD-9 codes: 540.0, K35.2) \* Acute appendicitis with peritonitis (ICD-9 codes: 540.0, K35.2) \* \*\*Major:\*\* \* Post-appendectomy (s/p appendectomy) \* Post-exploratory laparoscopy (s/p exploratory laparoscopy)

The diagnoses suggest a complex gastrointestinal issue requiring surgical intervention and subsequent ICU monitoring.

\*\*4. Treatments\*\*

The patient received the following treatments during their ICU stay:

\* \*\*Imaging:\*\* CT scan of the pelvis and abdomen. \* \*\*Medications:\*\* Metronidazole (antibiotic), Ondansetron (antiemetic), Ertapenem (carbapenem antibiotic). \* \*\*Fluid Management:\*\* Normal saline administration. \* \*\*Pain Management:\*\* Bolus parenteral analgesics. \* \*\*Respiratory Support:\*\* Oxygen therapy via nasal cannula (<40%).

All treatments listed were active at the time of discharge from the unit.

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

NULL. Sufficient data to generate vital sign trends over time is not included in the provided dataset. Data would need to include time-stamped measurements of heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation.

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

The following lab results were recorded at approximately 6 minutes post-unit admission:

\* \*\*Sodium:\*\* 134 mEq/L \* \*\*Albumin:\*\* 3.8 g/dL \* \*\*Creatinine:\*\* 1.4 mg/dL \* \*\*Glucose:\*\* 130 mg/dL \* \*\*Hematocrit (Hct):\*\* 42.7% \* \*\*Blood Urea Nitrogen (BUN):\*\* 11 mg/dL \* \*\*White Blood Cell Count (WBC):\*\* 17.3 K/mcL \* \*\*FiO2:\*\* 28% \* \*\*Total Bilirubin:\*\* 1.0 mg/dL

NULL. Sufficient data to generate lab trends over time is not provided. Time-stamped lab results are needed to generate informative trends. This data would ideally include additional lab results and repeat measurements.

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

NULL. No microbiology test results are included in this dataset.

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

The physical exam reveals the patient was alert and oriented (GCS 15) with stable vital signs upon admission to the ICU. The patient presented with elevated WBC suggesting an infectious process.

<sup>\* \*\*</sup>Physical Exam Performed:\*\* Yes, a structured physical exam was documented. \* \*\*Weight (Admission):\*\* 86.1 kg \* \*\*Glasgow Coma Scale (GCS):\*\* 15 (Eyes: 4, Verbal: 5, Motor: 6) \* \*\*Heart Rate:\*\* 101 bpm \* \*\*Blood Pressure (Systolic):\*\* 131 mmHg \* \*\*Blood Pressure (Diastolic):\*\* 68 mmHg \* \*\*Respiratory Rate:\*\* 23 breaths/min \* \*\*Oxygen Saturation:\*\* 98% \* \*\*FiO2:\*\* 28% \* \*\*Respiratory Mode:\*\* Spontaneous