**Medical Report for Patient 004-1044**

**1. Patient Information**

* **Patient Unit Stay ID:** 326308 * **Unique Patient ID:** 004-1044 * **Gender:** Female * **Age:** 75 * **Ethnicity:** Caucasian * **Admission Height:** 165.1 cm * **Admission Weight:** 61.7 kg * **Hospital Admission Time:** 2015-XX-XX 19:22:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 00:30:00 * **Hospital Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 00:20:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 00:30:00 * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive

**2. History**

Admission diagnosis was Rhythm disturbance (atrial, supraventricular). The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU. Further details regarding the patient's medical history prior to this ICU stay are not available in the provided data.

**3. Diagnoses**

* **Primary Diagnosis:** Atrial Fibrillation (427.31, I48.0) - Active upon discharge. * **Major Diagnosis:** COPD (491.20, J44.9) - Not active upon discharge. The COPD diagnosis was recorded twice, once as active upon discharge and once inactive. This discrepancy requires clarification in the complete medical record.

**4. Treatments**

The patient received the following treatments during their ICU stay:

* **Active upon discharge:** * Low molecular weight heparin (VTE prophylaxis) * Diltiazem (Class IV antiarrhythmic) * Ondansetron (serotonin antagonist antiemetic) * Pantoprazole (stress ulcer prophylaxis) * Bronchodilator * **Not active upon discharge:** * Ondansetron (serotonin antagonist antiemetic) * Low molecular weight heparin (VTE prophylaxis) * Diltiazem (Class IV antiarrhythmic) * Pantoprazole (stress ulcer prophylaxis) * Bronchodilator

Note the duplication and discrepancies in treatment records. This requires further investigation and reconciliation with the full medical chart. The timing of treatment initiation and cessation is not included in this data.

**5. Vital Trends**

* **Heart Rate (HR):** Current: 96 bpm, Lowest: 96 bpm, Highest: 97 bpm * **Blood Pressure (BP):** Systolic: Current: 123 mmHg, Lowest: 120 mmHg, Highest: 143 mmHg; Diastolic: Current: 74 mmHg, Lowest: 77 mmHg, Highest: 84 mmHg * **Respiratory Rate (RR):** Current: 19 breaths/min, Lowest: 19 breaths/min, Highest: 24 breaths/min * **Oxygen Saturation (O2 Sat):** Current: 92%, Lowest: 92%, Highest: 92%

**6. Lab Trends**

The following lab results were recorded at approximately the same time (53 minutes post unit admission):

* **Sodium:** 144 mmol/L * **Glucose:** 101 mg/dL * **Albumin:** 3.4 g/dL * **Creatinine:** 0.7 mg/dL * **BUN:** 15 mg/dL * **WBC x 1000:** 6.4 K/mcL * **Hct:** 38.6% * **FiO2:** 21%

**7. Microbiology Tests**

NULL – No microbiology test data provided.

**8. Physical Examination Results**

* **Glasgow Coma Scale (GCS):** Total Score: 14; Eye Opening: 4; Verbal Response: 4; Motor Response: 6 * **Weight:** 61.7 kg (Admission weight only)

**Note:** Several data points, particularly related to treatment and diagnosis timing and consistency, need further investigation to fully understand the patient's course during this ICU stay. The absence of time-series data for vital signs and lab results limits the analysis that can be performed. The full medical record should be reviewed for a more complete picture.