

## **\*\*Patient Information\*\***

Patient Unit Stay ID: 393867 Unique Patient ID: 004-10309 Gender: Male Age: 52 Ethnicity: Caucasian Hospital Admission Time: 2015-XX-XX 16:05:00 Hospital Admission Source: Floor Hospital Discharge Time: 2015-XX-XX 12:05:00 Hospital Discharge Location: Other Hospital Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admission Time: 2015-XX-XX 15:13:00 Unit Admission Source: Floor Unit Discharge Time: 2015-XX-XX 19:16:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Height (cm): 187.9 Admission Weight (kg): 44.7 Discharge Weight (kg): NULL Admission Diagnosis: Cardiovascular medical, other

## **\*\*Medical History\*\***

NULL (Insufficient data provided to elaborate on the patient's past medical history. Only current diagnoses during this ICU stay are available.)

## **\*\*Diagnoses\*\***

The patient presented with the following diagnoses during their ICU stay:

\* **\*\*Primary Diagnosis:\*\*** Atrial Fibrillation (ICD-9: 427.31, I48.0) \* **\*\*Major Diagnosis:\*\*** Cellulitis (ICD-9: 682.9, L03.90) \* **\*\*Major Diagnosis:\*\*** Diabetes Mellitus (ICD-9: ) \* **\*\*Major Diagnosis:\*\*** Hypertension (ICD-9: 401.9, I10)

## **\*\*Treatments\*\***

The patient received the following treatments during their ICU stay:

\* Piperacillin/Tazobactam (Therapeutic Antibacterials) \* Diltiazem (Class IV Antiarrhythmic) \* Oral Feeds (Enteral Nutrition) \* Surgery Consultation \* Lisinopril (ACE Inhibitor) \* Sliding Scale Insulin Administration

## **\*\*Vital Trends\*\***

The following vital signs were recorded:

\* Heart Rate (HR): Current 118 bpm, Lowest 118 bpm, Highest 123 bpm \* Blood Pressure (BP): Systolic - Current 153 mmHg, Lowest 134 mmHg, Highest 153 mmHg; Diastolic - Current 99 mmHg, Lowest 78 mmHg, Highest 120 mmHg \* Respiratory Rate (RR): Current 25 breaths/min, Lowest 25 breaths/min, Highest 33 breaths/min \* Oxygen Saturation (O2 Sat): Current 97%, Lowest 97%, Highest 97%

## **\*\*Lab Trends\*\***

The following lab results were obtained:

\* BUN: 10 mg/dL \* Creatinine: 0.7 mg/dL \* Hematocrit (Hct): 37% \* White Blood Cell Count (WBC): 19.9 K/mcL

## **\*\*Microbiology Tests\*\***

NULL (No microbiology test data was provided.)

## **\*\*Physical Examination Results\*\***

A structured physical exam was performed. Specific details beyond vital signs (listed above) are not available in the provided data.

**\*\*Note:\*\*** This report is based solely on the provided data. Additional information may be necessary for a comprehensive medical assessment. The absence of data in certain sections indicates that the information was not available in the source data.