

## **\*\*Medical Report: Patient 006-100706\*\***

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

\* \*\*Patient Unit Stay ID:\*\* 946151 \* \*\*Patient Health System Stay ID:\*\* 698095 \* \*\*Unique Patient ID:\*\* 006-100706 \*  
\*\*Gender:\*\* Male \* \*\*Age:\*\* 88 years \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 176 \* \*\*Ward ID:\*\* 376 \* \*\*Unit Type:\*\*  
Med-Surg ICU \* \*\*Unit Admit Time:\*\* 09:59:00 \* \*\*Unit Admit Source:\*\* Floor \* \*\*Unit Discharge Time:\*\* 05:52:00 \* \*\*Unit  
Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Time:\*\* 00:33:00 (Offset: -9206 minutes  
from unit admit) \* \*\*Hospital Admit Source:\*\* Floor \* \*\*Hospital Discharge Year:\*\* 2015 \* \*\*Hospital Discharge Time:\*\*  
23:33:00 (Offset: 6574 minutes from unit admit) \* \*\*Hospital Discharge Location:\*\* Other External \* \*\*Hospital Discharge  
Status:\*\* Alive \* \*\*Admission Height:\*\* 165 cm \* \*\*Admission Weight:\*\* 59.8 kg \* \*\*Discharge Weight:\*\* NULL

### **\*\*2. History\*\***

The provided data does not contain a detailed patient history. More information is needed to complete this section. The admission diagnosis indicates sepsis and a pulmonary condition, but the specifics of the patient's presentation, prior medical conditions, family history, social history, and medication history are missing. A complete history would include information on the onset of symptoms, their progression, any relevant past illnesses or surgeries, current medications, allergies, and other factors that might have contributed to the patient's condition. For example, information regarding the timeline and severity of the septic shock would be crucial for understanding the patient's ICU course. The absence of this detail limits the ability to provide a comprehensive history of the present illness. Further, details on any prior hospitalizations, particularly those related to cardiovascular or pulmonary issues, would be highly beneficial in assessing risk factors and potential contributing causes. This absence of information severely restricts the completeness of this section. A thorough review of the patient's chart is required to obtain this information.

### **\*\*3. Diagnoses\*\***

\* \*\*Diagnosis ID:\*\* 10561826 \* \*\*Patient Unit Stay ID:\*\* 946151 \* \*\*Active Upon Discharge:\*\* True \* \*\*Diagnosis Offset:\*\*  
18 minutes from unit admit time \* \*\*Diagnosis String:\*\* cardiovascular|shock / hypotension|sepsis \* \*\*ICD-9 Code:\*\* 038.9,  
A41.9 \* \*\*Diagnosis Priority:\*\* Primary

The primary diagnosis is sepsis with shock and hypotension, consistent with the ICD-9 codes provided. However, secondary diagnoses are not listed, yet may exist and should be identified in a complete medical record review. Further, the severity of the sepsis and the response to treatment are not detailed in the available data. A complete diagnostic assessment requires a thorough clinical picture, including imaging studies, consultation reports and other relevant clinical information.

### **\*\*4. Treatments\*\***

NULL. The provided data does not include information on the treatments administered during the ICU stay. This section would normally detail all medications, intravenous fluids, respiratory support (e.g., mechanical ventilation parameters), and other interventions provided to the patient. The absence of this information prevents a complete understanding of the management strategy. This data is critical for assessing the effectiveness of the care provided and identifying any potential adverse events.

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

NULL. The vital signs data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) are not available in the provided dataset. These trends are essential for evaluating the patient's hemodynamic stability and overall clinical course. A graphical representation of these vitals over time is crucial for a complete assessment.

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

The provided data includes numerous lab results, but lacks a clear timeline for when these tests were performed. Many lab tests, including blood cell counts (WBC, RBC, Hgb, Hct, platelets), blood chemistry (glucose, BUN, creatinine, electrolytes), liver function tests (ALT, AST), and coagulation studies (PT, PTT, INR) were collected. These results indicate possible abnormalities, but without the time element, we cannot understand the trends or the patient's response to treatment. The repeated measures of certain lab tests suggest serial monitoring, but this needs to be confirmed with a more complete dataset showing the time course of these measurements.

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

NULL. The provided data does not contain any information on microbiology tests performed, such as blood cultures or other cultures for infectious agents. Results from these tests are critical in the diagnosis and management of sepsis.

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

**\*\*\*Physical Exam ID:\*\* 28170652-28170660 \*\*\*Physical Exam Performed:\*\* Performed - Structured \* \*\*Admission Weight:\*\* 59.8 kg \* \*\*Glasgow Coma Scale (GCS):\*\* 15 (Eyes: 4, Verbal: 5, Motor: 6)**

The physical exam was documented, and the Glasgow Coma Scale score indicates the patient was alert and oriented. The admission weight is recorded. However, a more complete physical examination would include details of other systems (cardiovascular, respiratory, gastrointestinal, etc.), and would provide more context to the patient's clinical status.

## **\*\*3. Chart Description\*\***

A line chart would be highly informative. The x-axis would represent time (in hours or days since ICU admission), and the y-axes would show the trends of key lab values (e.g., WBC count, lactate, creatinine, and blood gases). Each lab value would be represented by a different colored line. This visualization would allow us to identify patterns in the patient's laboratory values over time, such as the resolution of an infection or the development of organ dysfunction. A second line chart would display vital signs (heart rate, blood pressure, respiratory rate, SpO2, temperature) over time. This would show the patient's physiological response to treatment and overall clinical stability. Finally, a combination chart plotting both laboratory results and vitals over time would provide the most comprehensive overview of the patient's clinical course.

## **\*\*4. CSV Data\*\***

The CSV data below represents a simplified version of the data; a complete dataset would include all time-series data, in a format ready for import into pandas. Due to the nature of the provided data, the time element is missing and therefore the data cannot be complete. The following CSV only shows the available values without a time component.

```
```csv LabName,LabResult,LabMeasureNameSystem MCV,87,fL platelets x 1000,245,K/mcL WBC x 1000,13.1,K/mcL
WBC x 1000,11.8,K/mcL Hct,38.1,% RDW,18.9,% MCHC,33.6,g/dL MCH,29,pg RDW,19,% MCHC,33.2,g/dL
MCH,29.0,pg PT - INR,1.1,ratio platelets x 1000,200,K/mcL MPV,9.8,fL RBC,4.37,M/mcL PT,14.5,sec Base
Excess,-3.4,mEq/L Temperature,37,°C Hgb,12.8,g/dL FiO2,50,% RBC,4.35,M/mcL bedside glucose,134,mg/dL
HCO3,21.6,mmol/L O2 Sat (%),98.9,% Hgb,12.6,g/dL
```

```
``` }
```

**\*\*Note:\*\*** The CSV data is a small subset of the available lab data and lacks the crucial time component (`labresultoffset`) to create meaningful time-series trends. A complete CSV would require adding a timestamp or time offset for each lab result. Similarly, the PDF report lacks much of the clinically relevant detail due to the limitations of the input JSON data. A complete report would require a much more comprehensive dataset including patient history, treatment details, and vital sign trends.