

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

\*\*\*Patient ID:\*\* 002-11375 \*\*\*Patient Unit Stay ID:\*\* 149432 \*\*\*Patient Health System Stay ID:\*\* 135332 \*\*\*Gender:\*\* Female \*\*\*Age:\*\* 34 \*\*\*Ethnicity:\*\* Caucasian \*\*\*Hospital ID:\*\* 68 \*\*\*Ward ID:\*\* 103 \*\*\*Admission Diagnosis:\*\* NULL \*\*\*Admission Height:\*\* 165.1 cm \*\*\*Hospital Admit Time:\*\* 2015-XX-XX 05:37:41 \*\*\*Hospital Admit Source:\*\* Emergency Department \*\*\*Hospital Discharge Year:\*\* 2015 \*\*\*Hospital Discharge Time:\*\* 2015-XX-XX 14:05:00 \*\*\*Hospital Discharge Location:\*\* Other \*\*\*Hospital Discharge Status:\*\* Alive \*\*\*Unit Type:\*\* SICU \*\*\*Unit Admit Time:\*\* 2015-XX-XX 07:38:00 \*\*\*Unit Admit Source:\*\* ICU to SDU \*\*\*Unit Visit Number:\*\* 2 \*\*\*Unit Stay Type:\*\* stepdown/other \*\*\*Admission Weight:\*\* NULL \*\*\*Discharge Weight:\*\* 61 kg \*\*\*Unit Discharge Time:\*\* 2015-XX-XX 14:05:00 \*\*\*Unit Discharge Location:\*\* Other \*\*\*Unit Discharge Status:\*\* Alive

\*\*2. History:\*\*

Insufficient data provided to generate a detailed patient history. The report only includes admission and discharge times and locations, along with basic demographics. Further information is needed regarding presenting symptoms, past medical history, family history, social history, and medication history. The admission diagnosis is also missing. This section would normally include a narrative description of the events leading to the patient's admission to the ICU.

\*\*3. Diagnoses:\*\*

NULL. No diagnoses are explicitly listed in the provided data. This section requires information from the patient's chart, including confirmed diagnoses based on clinical findings and investigations. A complete diagnostic assessment is essential for a comprehensive medical report.

\*\*4. Treatments:\*\*

NULL. The provided data does not contain information about the treatments administered during the ICU stay. This section should detail all medications, procedures, and therapies received by the patient. This would include dosages, routes of administration, and response to therapy.

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

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is available in the dataset. A graphical representation of vital sign trends over time is crucial for assessing the patient's physiological stability and response to interventions.

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

The following laboratory results are available:

Lab Name	Result	Units	Time Offset (minutes)	----- ----- ----- -----	Sodium	143									
mmol/L	127	Hgb	12.7	g/dL	127	BUN	14	mg/dL	127	Platelets x 1000	277	K/mcL	127	Anion Gap	15
mmol/L	127	RDW	12.6	%	127	Bicarbonate	24	mmol/L	127	MCHC	33.4	g/dL	127	Calcium	7.8
mg/dL	127	MCV	92.9	fL	127	Chloride	108	mmol/L	127	MCH	31.1	pg	127	Glucose	99
WBC x 1000	7.2	K/mcL	127	Creatinine	0.6	mg/dL	127	RBC	4.09	M/mcL	127	Potassium	3.6	mmol/L	127
Hct	38	%	127	Magnesium	1.8	mg/dL	127								

Note: All lab results were obtained at 127 minutes from unit admit time. Trends cannot be assessed with a single time point.

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

NULL. No microbiology test results are included in the provided data. This section would typically report the results of blood cultures, urine cultures, and other relevant microbiological investigations.

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

NULL. No physical examination findings are provided. A detailed description of the patient's physical examination upon admission and during the ICU stay is needed for a complete medical report. This typically includes observations of vital signs, general appearance, and assessment of each body system.