Medical Report: Patient 003-10109

1. Patient Information

* **Patient Unit Stay ID:** 287848 * **Unique Patient ID:** 003-10109 * **Gender:** Male * **Age:** 62 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 22:34:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 16:00:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 22:39:00 * **Unit Admit Source:** Direct Admit * **Unit Discharge Time:** 2015-XX-XX 20:57:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 46.8 kg * **Discharge Weight:** 47.6 kg * **Admission Height:** 172.72 cm

2. History

NULL (Insufficient data provided for a detailed patient history. The provided data only includes diagnoses and treatments, lacking information about presenting symptoms, prior medical history, family history, social history, etc.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These diagnoses, in order of entry, were:

* **Pneumonia:** (ICD-9 code: 486, J18.9) Entered 22 minutes after unit admission. This diagnosis was active upon discharge from the unit. * **Signs and Symptoms of Sepsis (SIRS):** (ICD-9 code: 995.90) Entered 22 and 33 minutes after unit admission. This diagnosis was active upon discharge from the unit. * **Fever:** (ICD-9 code: 780.6, R50.9) Entered 33 and 197 minutes after unit admission. This diagnosis was active upon discharge from the unit. * **Sepsis:** (ICD-9 code: 038.9, A41.9) Entered 33 and 197 minutes after unit admission. This diagnosis was active upon discharge from the unit. * **COPD:** (ICD-9 code: 491.20, J44.9) Entered 22 and 197 minutes after unit admission. This diagnosis was active upon discharge from the unit. * **Leukocytosis:** (ICD-9 code: 288.8, D72.829) Entered 33 and 197 minutes after unit admission. This diagnosis was active upon discharge from the unit.

Note that multiple entries for the same diagnosis exist, reflecting updates or re-assessments during the patient's stay. The `activeupondischarge` flag indicates whether the diagnosis was considered active at the time of unit discharge.

4. Treatments

The patient received the following treatments during their ICU stay:

* **Oxygen Therapy (< 40%), Nasal Cannula:** Started 22 minutes after unit admission; discontinued at some point before unit discharge. * **Oxygen Therapy (40% to 60%), Face Mask:** Started 1036 minutes after unit admission; active at the time of unit discharge. * **Glucocorticoid Administration:** Started 1036 minutes after unit admission; active at the time of unit discharge. * **Antibacterials:** Started 1036 minutes after unit admission; active at the time of unit discharge. * **Stress Ulcer Prophylaxis:** Started 1036 minutes after unit admission; active at the time of unit discharge. * **VTE Prophylaxis:** Administered at 33 minutes and 1036 minutes after unit admission. * **Cultures:** Administered at 22 and 33 minutes after unit admission. * **Sedative Agent:** Administered 197 minutes after unit admission.

5. Vital Trends

* **Initial Vitals (9 minutes post-admission):** Heart Rate (HR): 122 bpm, Blood Pressure (BP): 109/71 mmHg, Respiratory Rate: 21 breaths/min, O2 Saturation (SpO2): 93%, FiO2: 32% * **GCS Score (9 minutes post-admission):** 15 (Eyes: 4, Verbal: 5, Motor: 6) * **Physical Exam:** The patient was initially noted as ill-appearing but not in acute distress. A later physical exam (1033 minutes post-admission) was not performed.

6. Lab Trends

(See summary table below)

7. Microbiology Tests

Cultures were obtained early in the patient's stay (22 and 33 minutes post admission). Results are not provided.

8. Physical Examination Results

(See Vital Trends above)