

****Medical Report for Patient 007-10609****

****1. Patient Information****

****Patient Unit Stay ID:**** 961164 ****Unique Patient ID:**** 007-10609 ****Gender:**** Female ****Age:**** 84 ****Ethnicity:**** Caucasian ****Hospital Admit Time:**** 2015-XX-XX 04:32:00 ****Hospital Admit Source:**** Emergency Department ****Hospital Discharge Time:**** 2015-XX-XX 18:57:00 ****Hospital Discharge Location:**** Skilled Nursing Facility ****Hospital Discharge Status:**** Alive ****Unit Type:**** Med-Surg ICU ****Unit Admit Time:**** 2015-XX-XX 12:51:00 ****Unit Admit Source:**** Emergency Department ****Unit Discharge Time:**** 2015-XX-XX 02:14:00 ****Unit Discharge Location:**** Telemetry ****Unit Discharge Status:**** Alive ****Admission Weight:**** 102.9 kg ****Discharge Weight:**** 102.7 kg ****Admission Height:**** 165.1 cm

****2. History****

Admission history is not explicitly provided in the data, but the patient was admitted to the hospital from the Emergency Department and subsequently to the Med-Surg ICU. The admission diagnosis was GI obstruction. The patient's ICU stay lasted approximately 2243 minutes (37 hours and 23 minutes). Further details regarding the patient's medical history prior to admission are unavailable in the provided data. A more comprehensive history would be needed for a complete evaluation.

****3. Diagnoses****

****Diagnosis ID:**** 12749203 ****Patient Unit Stay ID:**** 961164 ****Active Upon Discharge:**** True ****Diagnosis Offset (minutes from unit admit):**** 31 ****Diagnosis String:**** gastrointestinal|abdominal/ general|abdominal pain / tenderness ****ICD-9 Code:**** 789.00, R10.9 ****Diagnosis Priority:**** Other

The primary diagnosis upon ICU admission was abdominal pain and tenderness, classified as 'Other' priority. The ICD-9 codes suggest nonspecific abdominal pain and unspecified symptoms. The lack of primary diagnosis information necessitates a more detailed clinical assessment.

****4. Treatments****

The following treatments were administered during the patient's ICU stay:

****Treatment ID:**** 27948764; ****Treatment String:**** gastrointestinal|radiology, diagnostic and procedures|CT scan ****Treatment ID:**** 27917280; ****Treatment String:**** gastrointestinal|consultations|Gastroenterology consultation ****Treatment ID:**** 28060995; ****Treatment String:**** renal|intravenous fluid|normal saline administration ****Treatment ID:**** 27855403; ****Treatment String:**** gastrointestinal|medications|analgesics ****Treatment ID:**** 28007069; ****Treatment String:**** pulmonary|medications|antibacterials

All treatments were active upon discharge from the unit. The treatments suggest a multidisciplinary approach to manage the patient's abdominal pain, including imaging (CT scan), gastroenterology consultation, intravenous fluids, analgesics, and antibacterials (potentially to address an infection).

****5. Vital Trends****

NULL. Vital signs data are not included in the provided dataset.

****6. Lab Trends****

The provided data includes multiple lab results, with some repeated tests over time. A detailed analysis of these trends would require time-series plotting and statistical analysis to identify patterns over time. Initial observations suggest

fluctuations in glucose levels, and electrolyte imbalances (sodium, potassium, chloride, bicarbonate) along with elevated liver enzymes (AST, ALT) and lipase.

****7. Microbiology Tests****

NULL. Microbiology test results are not available in the provided dataset.

****8. Physical Examination Results****

A structured physical exam was performed. The Glasgow Coma Scale (GCS) was recorded as 15 (Eyes 4, Verbal 5, Motor 6). Heart rate was 88 bpm. The systolic blood pressure was 158 mmHg (lowest 132 mmHg, highest 158 mmHg), and diastolic blood pressure was 95 mmHg (lowest 75 mmHg, highest 95 mmHg). Respiratory rate was 18 breaths per minute. Admission weight was 102.9 kg and remained unchanged during the stay.