Patient Information

Patient Unit Stay ID: 903409 Unique Patient ID: 006-102318 Gender: Male Age: 70 Ethnicity: Caucasian Hospital Admission Time: 2014-XX-XX 17:40:00 Hospital Discharge Time: 2014-XX-XX 18:30:00 Unit Admission Time: 2014-XX-XX 23:25:00 Unit Discharge Time: 2014-XX-XX 15:58:00 Unit Type: Med-Surg ICU Admission Weight (kg): 72.2 Discharge Weight (kg): 74.4 Hospital Admission Source: Recovery Room Unit Admission Source: Recovery Room Hospital Discharge Location: Home Unit Discharge Location: Step-Down Unit (SDU) Hospital Discharge Status: Alive Unit Discharge Status: Alive

Medical History

Insufficient information provided to generate a detailed medical history. The provided data only includes the admission and discharge times and locations, along with some basic demographics. A complete medical history would require additional information such as past medical conditions, surgeries, allergies, family history, and social history. Further details on the events leading to the ICU admission are also needed.

Diagnoses

Diagnosis ID: 11359401 Active upon Discharge: True Diagnosis Offset (minutes from unit admit): 12 Diagnosis String: neurologic|trauma - CNS|intracranial injury|with subdural hematoma ICD-9 Code: 852.20, S06.5 Diagnosis Priority: Primary

This indicates a primary diagnosis of subdural hematoma requiring neurosurgical intervention, as evidenced by the treatment information below. More detailed information on the patient's neurological status, including the evolution of symptoms prior to admission and response to treatment, is required for a comprehensive assessment.

Treatments

Treatment ID: 26102274 Treatment Offset (minutes from unit admit): 12 Treatment String: neurologic|procedures / diagnostics|neurosurgery|therapeutic craniotomy|for hematoma Active upon Discharge: True

The patient underwent a therapeutic craniotomy for the subdural hematoma. Information regarding the specifics of the surgery (e.g., extent of resection, complications), post-operative course, and any other interventions (e.g., medication administration) is missing.

Vital Trends

NULL. No vital sign data was provided.

Lab Trends

Two sets of complete blood count (CBC) results are available, one at approximately 650 minutes and another at -105 minutes post unit admission. The data shows the following:

* **Hemoglobin (Hgb):** Initially 11.4 g/dL (-105 minutes), then 10.5 g/dL (650 minutes). This suggests a slight decrease in hemoglobin levels over time. * **Hematocrit (Hct):** Initially 33.4% (-105 minutes), then 31.3% (650 minutes). Similar to hemoglobin, this indicates a slight decrease. * **Platelets:** Initially 106 K/mcL (-105 minutes), then 95 K/mcL (650 minutes). A modest decrease is observed. * **White Blood Cells (WBC):** Initially 4.5 K/mcL (-105 minutes), then 2.6 K/mcL (650 minutes). A more significant decrease in WBC count is observed. * **Mean Corpuscular Volume (MCV):** 95 fL (-105 minutes), 97 fL (650 minutes). A slight increase is noted. * **Mean Corpuscular Hemoglobin Concentration (MCHC):** 34 g/dL (-105 minutes), 34 g/dL (650 minutes). No change observed. * **Mean Platelet Volume (MPV):** 9.6 fL (-105 minutes), 9.7 fL (650 minutes). A slight increase is observed. * **Red Cell Distribution Width (RDW):** 14.4% (-105 minutes), 14.4% (650 minutes). No change is observed. * **Mean Corpuscular Hemoglobin (MCH):** 32.5 pg (-105

minutes), 32.4 pg (650 minutes). A slight decrease is observed. * **Red Blood Cells (RBC):** 3.51 M/mcL (-105 minutes), 3.24 M/mcL (650 minutes). There is a noticeable decrease in RBC count. * **FiO2:** 31% (13 minutes). This represents the fraction of inspired oxygen. This single measurement suggests the patient required supplemental oxygen.

Additional lab data (e.g., electrolytes, coagulation studies) would be necessary to complete the evaluation.

Microbiology Tests

NULL. No microbiology test data was provided.

Physical Examination Results

Physical Exam performed: A structured physical exam was performed. The Glasgow Coma Scale (GCS) was documented at the time of the exam. It is scored as 15 (Eyes: 4, Verbal: 5, Motor: 6). Admission weight was 72.2 kg. Current weight is 72.2 kg. Weight change is 0kg.

Additional details of the physical examination are needed for a comprehensive evaluation, including information on respiratory, cardiovascular, gastrointestinal, and other systems.