Medical Report for Patient 004-10029

1. Patient Information

* **Patient Unit Stay ID:** 418417 * **Unique Patient ID:** 004-10029 * **Gender:** Female * **Age:** 57 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-00-00 00:20:00 * **Hospital Discharge Time:** 2015-00-00 16:35:00 * **Unit Admission Time:** 2015-00-00 11:57:00 * **Unit Discharge Time:** 2015-00-00 21:12:00 * **Admission Weight:** 73.94 kg * **Admission Height:** 162.5 cm * **Hospital Admit Source:** Emergency Department * **Unit Admit Source:** Emergency Department * **Hospital Discharge Status:** Alive * **Unit Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Ward ID:** 176 * **Hospital ID:** 133 * **APACHE Admission Dx:** Pneumonia, other

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis was pneumonia (ICD-9 code: 486, J18.9), initially recorded 60 minutes after unit admission and remaining active upon discharge. Other significant diagnoses included:

* **Pneumonia (486, J18.9):** Multiple entries indicate ongoing concern and treatment. The diagnosis was marked as Primary and was active upon discharge. * **Transient Ischemic Attack (TIA) (435.9, G45.9):** Recorded as a Major diagnosis, this suggests a neurological event. Multiple entries show this was addressed throughout the stay. * **Hematuria (599.7, R31.9):** A Major diagnosis indicating blood in the urine, suggesting potential renal involvement. This was a recurring concern during the stay.

4. Treatments

The patient received extensive treatment during her ICU stay. Significant treatments included:

* **Antibiotics:** Ceftriaxone and levofloxacin were administered to address the pneumonia. * **Analgesics:** Acetaminophen and ketorolac were used for pain management. * **Antiemetic:** Ondansetron was administered to control nausea and vomiting. * **Anticonvulsants:** Valproate and gabapentin were prescribed to address or prevent seizures (potentially related to the TIA). * **Stress Ulcer Prophylaxis:** Pantoprazole was administered to prevent stress ulcers. * **VTE Prophylaxis:** Compression stockings were used to prevent venous thromboembolism. * **IV Fluids:** Normal saline was administered. * **Oxygen Therapy:** The patient received oxygen therapy, with FiO2 levels ranging to 28% at times, highlighting respiratory distress. * **Enteral Feeds:** Oral feeds were provided for nutritional support. * **Diagnostic Imaging:** CT scans of the abdomen and pelvis were performed. * **Cultures:** Blood and urine cultures were obtained to identify the causative organism of the pneumonia.

5. Vital Trends

NULL (Insufficient information provided to generate trends)

6. Lab Trends

The following lab results were obtained:

* **Creatinine:** 1.0 mg/dL * **Albumin:** 2.5 g/dL * **Sodium:** 139 mEq/L * **Glucose:** 113 mg/dL * **Total Bilirubin:** 0.6 mg/dL * **WBC x 1000:** 17.2 K/mcL * **FiO2:** 28% * **Hct:** 35.1% * **BUN:** 35 mg/dL

NULL (Insufficient information provided to generate trends)

7. Microbiology Tests

NULL (Insufficient data to report specific results)

8. Physical Examination Results

Physical exam performed, and vital signs documented. Heart rate (HR) ranged from 69 to 70 bpm, blood pressure (BP) systolic from 78 to 87 mmHg, diastolic from 48 to 53 mmHg, respiratory rate (RR) from 14 to 15 breaths per minute, and oxygen saturation (O2 Sat) from 94 to 96%. The patient's GCS score was documented as 15, with Motor score 6, Verbal score 5, and Eye score 4. The admission weight was 73.94 kg.