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**Patient Medical Report**
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\*\*1. Patient Information\*\*

\*\*\*PatientUnitStayID:\*\* 926319 \* \*\*PatientHealthSystemStayID:\*\* 686311 \* \*\*Gender:\*\* Female \* \*\*Age:\*\* 78 \* 
\*\*Ethnicity:\*\* Caucasian \* \*\*HospitalID:\*\* 154 \* \*\*WardID:\*\* 394 \* \*\*Admission Diagnosis:\*\* Emphysema/bronchitis \* 
\*\*Admission Height:\*\* 162.5 cm \* \*\*Hospital Admit Time:\*\* 23:43:00 \* \*\*Hospital Admit Source:\*\* Floor \* \*\*Hospital Discharge Year:\*\* 2014 \* \*\*Hospital Discharge Time:\*\* 01:58:00 \* \*\*Hospital Discharge Location:\*\* Other External \* 
\*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 14:09:00 \* \*\*Unit Admit Source:\*\* Floor \* \*\*Unit Visit Number:\*\* 3 \* \*\*Unit Stay Type:\*\* readmit \* \*\*Admission Weight:\*\* 74.9 kg \* \*\*Discharge Weight:\*\* NULL \* \*\*Unit Discharge Time:\*\* 18:41:00 \* \*\*Unit Discharge Location:\*\* Step-Down Unit (SDU) \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Unique Patient ID:\*\* 006-100175

\*\*2. History\*\*

NULL (Insufficient data provided)

\*\*3. Diagnoses\*\*

The patient presented with multiple diagnoses during her ICU stay. The diagnoses, their priority, and active status upon discharge are detailed below:

\*\*\*Diagnosis 1 (Major, Active upon Discharge):\*\* pulmonary|disorders of the airways|COPD (ICD-9 code: 491.20, J44.9). This diagnosis was recorded 3465 minutes after unit admission. \* \*\*Diagnosis 2 (Major, Active upon Discharge):\*\* pulmonary|respiratory failure|acute respiratory failure (ICD-9 code: 518.81, J96.00). This diagnosis was recorded 3465 minutes after unit admission. \* \*\*Diagnosis 3 (Primary, Not Active upon Discharge):\*\* cardiovascular|shock / hypotension|sepsis|severe (ICD-9 code: 995.92, R65.2). This diagnosis was recorded 76, 789 minutes after unit admission. \* \*\*Diagnosis 4 (Major, Not Active upon Discharge):\*\* pulmonary|respiratory failure|acute respiratory failure (ICD-9 code: 518.81, J96.00). Multiple entries for this diagnosis were recorded at 76, 789, and 35 minutes after unit admission. \* \*\*Diagnosis 5 (Major, Not Active upon Discharge):\*\* pulmonary|disorders of the airways|COPD (ICD-9 code: 491.20, J44.9). Multiple entries for this diagnosis were recorded at 76, 789, and 35 minutes after unit admission. \* \*\*Diagnosis 6 (Primary, Active upon Discharge):\*\* cardiovascular|shock / hypotension|sepsis|severe (ICD-9 code: 995.92, R65.2). This diagnosis was recorded 3465 minutes after unit admission.

The multiplicity of entries for some diagnoses suggests potential revisions or updates to the initial assessments.

\*\*4. Treatments\*\*

The patient received several treatments during her ICU stay. The treatments and their active status upon discharge are listed below:

\* \*\*Treatment 1 (Not Active upon Discharge):\*\* pulmonary|ventilation and oxygenation|non-invasive ventilation. This treatment was initiated 13 minutes after unit admission. \* \*\*Treatment 2 (Not Active upon Discharge):\*\* cardiovascular|intravenous fluid|normal saline administration|fluid bolus (250-1000mls). This treatment was initiated 76 minutes after unit admission. \* \*\*Treatment 3 (Not Active upon Discharge):\*\* pulmonary|ventilation and oxygenation|mechanical ventilation. This treatment was initiated 76 and 789 minutes after unit admission.

The cessation of mechanical ventilation suggests a positive response to treatment, though further details are needed to fully understand the patient's clinical course.

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

NULL (Insufficient data provided)

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

The patient underwent numerous laboratory tests, including blood gas analyses and complete blood counts. Significant trends will be analyzed further. Key lab results include:

\* \*\*Blood Gas Analyses:\*\* Multiple measurements of pH, PaO2, PaCO2, and Base Excess were taken, indicating respiratory status monitoring. \* \*\*Complete Blood Count (CBC):\*\* Hemoglobin (Hgb), Hematocrit (Hct), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), Red Blood Cell (RBC) count, White Blood Cell (WBC) count, Platelet count, and Red cell distribution width (RDW) were all measured. These indicate monitoring of the patient's hematologic status. \* \*\*Chemistry Panel:\*\* Electrolytes like sodium, potassium, chloride, bicarbonate, glucose, BUN, creatinine, anion gap, albumin, total protein, total bilirubin, ALT, AST, and lactate were measured. These provide insights into overall metabolic health, hydration, and organ function. \* \*\*Drug Levels:\*\* Theophylline and Vancomycin trough levels were monitored. This shows medication levels were checked to ensure therapeutic levels were maintained.

Detailed analysis of the time series of these lab values is needed to identify trends and correlations with clinical events.

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

NULL (Insufficient data provided)

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

A structured physical exam was performed. The exam recorded a GCS score of 10 (Eyes 3, Verbal 1, Motor 6), systolic blood pressure (current, lowest, highest) of 166 mmHg, diastolic blood pressure (current, lowest, highest) of 87 mmHg, admission weight of 74.9kg, total intake of 0mL, total output of 550mL, and a net fluid balance of -550mL. More detailed physical exam findings are needed for a complete assessment.