Patient Information

Patient Unit Stay ID: 674731 Unique Patient ID: 006-106259 Gender: Female Age: 68 Ethnicity: Caucasian Hospital Admission Time: 2015, 13:13:00 Hospital Admission Source: Emergency Department Hospital Discharge Time: 2015, 00:12:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admission Time: 15:04:00 Unit Admission Source: Emergency Department Unit Discharge Time: 00:48:00 Unit Discharge Location: Acute Care/Floor Unit Discharge Status: Alive Admission Weight: 54 kg Discharge Weight: 75.1 kg Admission Height: 167 cm

Medical History

NULL (Insufficient data provided)

Diagnoses

NULL (Insufficient data provided)

Treatments

NULL (Insufficient data provided)

Vital Trends

Based on the available data, we can infer some vital sign information from the physical exam and lab results. A structured physical exam was performed at 10 minutes post unit admission. The Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6), indicating normal neurological function at the time of assessment. The patient's initial weight was recorded as 54 kg. The initial FiO2 was 40%, and the ventilator rate was 4 breaths per minute. Additional vital signs, such as heart rate, blood pressure, respiratory rate, and temperature, are not available in the provided dataset.

The lab results indicate a temperature of 37°C at -79 minutes from unit admit time and again at -179 minutes. The initial blood oxygen saturation (O2 Sat) was 99.7% at -179 minutes and 99.9% at -79 minutes. These values suggest adequate oxygenation at those time points. Further information is needed to create comprehensive vital sign trends across the entire ICU stay.

Lab Trends

The provided lab data includes multiple blood tests performed at various times during the patient's stay, including complete blood count (CBC) with differential, basic metabolic panel (BMP), and liver function tests (LFTs). The data is not consistently timestamped, making it impossible to create a comprehensive timeline of the lab results. However, we can make some observations:

* Hemoglobin (Hgb) levels show some fluctuation. The initial value of 15.3 g/dL decreased to 14.0 g/dL and then rose to 14.3 g/dL. This fluctuation warrants further analysis with a more complete dataset. * Hematocrit (Hct) levels follow a similar pattern to Hgb, with an initial value of 47%, followed by 43.4%, and then 44.3%. * White blood cell (WBC) count was initially elevated at 11.5 K/mcL, increased to 13.7 K/mcL, and then to 15.9 K/mcL, indicating a potential infection or inflammatory response. Again, more data is needed for a conclusive assessment. * Platelet counts show some variation: 299 K/mcL, 253 K/mcL, and then 256 K/mcL. * The potassium level was initially 3.8 mmol/L, increased to 4.4 mmol/L, and again to 3.8 mmol/L. * Blood glucose levels varied from 97 mg/dL to 142 mg/dL and then to 106 mg/dL. * Creatinine levels were initially 0.7 mg/dL and later 0.8 mg/dL and then 0.7 mg/dL. * The anion gap was consistently around 10. * Liver function tests (ALT, AST) showed mild elevations, suggesting possible liver involvement. * The initial blood gas analysis (ABG) showed a pH of 7.319, PaO2 of 361.5 mmHg, PaCO2 of 53.5 mmHg, HCO3 of 26.9 mmol/L, and a base excess of -0.3 mEq/L. A later ABG shows a pH of 7.341, PaO2 of 483.5 mmHg, PaCO2 of 45.5 mmHg, HCO3 of 24.1 mmol/L, and a base excess of -1.9 mEq/L. The changes in these values suggest possible respiratory compensation for metabolic

acidosis. * Vancomycin trough levels were measured at 6 mcg/mL and 13 mcg/mL, indicating medication administration.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

The physical exam documented at 10 minutes post unit admission included a GCS score of 15, indicating intact neurological function. The patient's admission weight was 54kg, FiO2 was 40%, and the ventilator rate was 4 breaths per minute. A more complete physical examination would provide additional insights into the patient's condition.