

HPI The patient is 69-year-old female, last seen on Wednesday, December 24, 2025, who presents with the following complaint(s):

Pressure ulcer of back stage 3 (Follow Up): The complaint involves Left Medial Lumbar Back - Lateral to L5.

Pressure ulcer of left lower leg stage 4 (Follow Up): The complaint involves Left Lateral Lower Leg - Proximal.

Visit #41

Tissue placement: Simplimax #5

Date of Visit: December 31st, 2025

Referring agency: Providence at Home

Duration of visit: 90 minutes

Initial Wound Size: 2.0 x 1.5 x 0.2 cm documented on 5/7/2024

Diagnosis codes: L89.523

Primary: L89.624 Pressure ulcer of left lower leg stage 4

Secondary: G82.52, I87.2

Colleen's wounds are showing significant healing progress. Objectively, they have decreased in size, and the wound beds are clean, non-infected, and contain new granulation tissue. The continued use of Simplimax biological tissue appears effective, and the alternating air pressure mattress is further aiding recovery by offloading the wounds and optimizing blood flow. Current Ankle-Brachial Index (ABI) and arterial vascular study results remain consistent with the findings from 2022 (details below).

Colleen Crawford is a 69 year old female with a medical history significant for C1-C4 quadriplegia, peripheral artery disease, chronic venous insufficiency, dyslipidemia, chronic pain and reactive depression. She presents with a chronic left lower extremity pressure ulcer. The wound has been present for over 9 months and was first measured and documented by her home health team in May of 2024. Initial onset of this pressure ulcer occurred due to quadriplegia, lack of mobility and wheelchair bound/bed bound status. The wound exhibits callus, biofilm, slough, undermining and mild serosanguinous discharge and has failed to heal despite on-going traditional and advanced wound care treatments over the last 90 days.

These treatments include home health and RN dressing changes three times weekly, cleansing with wound cleanser and packing with hydrofera blue, foam pads, absorbent dressings, frequent repositioning and elevation. Additionally, Colleen has been under my care at Premier Wound Healing with weekly debridement and advanced tissue placement for the last 4 months with significant response to treatment. Colleen received a 30 day notification letter from Premier Wound Healing stating that they were closing their business and she would need to find new wound care. Colleen has requested new service with Advanced Wound Care and Healing. On December 10th, 2024 it was noted that her wound burden was 2.5 x 2.2 x 0.4 cm. On March, 12th 2025 it was noted that her wound burden was 5.0 x 2.0 x 0.3 cm. Colleen does not smoke and does not have diabetes.

The chronic ulcer has failed to heal in a timely manner. Comorbidities such as quadriplegia, generalized weakness and being bed bound, exacerbate the condition by impairing circulation, delaying the inflammatory response, and reducing the overall capacity for tissue regeneration. The patient's mobility status, being largely wheelchair bound, further complicates healing as it restricts movement and increases pressure on vulnerable areas. Traveling to an office setting is not feasible for the patient, as she has mobility challenges and leaving home requires a taxing effort. The patient lives in a home with her husband in Beaverton, Or, where she receives daily care from a home health aid. She has been receiving twice weekly wound care visits from Providence Home Health and weekly advanced wound



care visits from Premier Wound Healing. She was discharged from her advanced wound care due to the provider of services going out of business.

Colleen also has a wound on her left lower back. Upon discharge from hospitalization for wound infection and resumption of tissue placement on August 13th, 2025 this wound measured 11.6 x 5.5 x 1.1 cm. This wound is improving and demonstrates new granulation tissue and has advanced from the inflammatory to the proliferative phase of wound healing. It has decreased slightly in size measuring 9.7 x 5.5 x 1.0 cm today. The wound on her leg measured 5.7 x 2.1 x 0.2 cm on August 13th, 2025. It is healing well and has decreased in size to 2.6 x 1.0 x 0.1 cm. Colleen does not have a fever today and her vital signs are stable.

I have discussed Colleen's nutritional status with her in detail. She states that she is on a high protein diet, that she supplements with protein powder and a daily protein shake. She does not smoke and she does not have Diabetes.

The patient has opted to continue at-home wound treatment. We extensively discussed the risks, benefits, and alternatives of this choice, specifically addressing potential complications such as infection, scarring, bleeding, prolonged or incomplete wound healing, allergic reaction to anesthesia, nerve injury, and recurrence.

Location and Progression:

- Wound Location: Left lower leg
- Size: 2.0 x 1.5 x 0.2 cm documented on 5/7/2024
- Characteristics: biofilm, callus, mild purulent discharge
- Duration: Wound has been present for greater than 9 months
- Progression: The wound has persisted despite consistent wound care.
- Pain: 3/10
- Wound status: The wound appears free from necrotic debris and infection.

Previous Treatments and Effectiveness:

- Cleansing with vashe and moistened gauze, packing with hydrofera blue with minimal improvement
- Dressing Changes: Home health RN changes dressing three times weekly, with assistance from home health aid
- Weekly advanced wound care with debridement and biologic tissue placement with steady Improvement

Information from Previous Correspondences, Admissions, and Progress Notes:

- There has been ongoing wound care from Providence Home Health and Premier Wound Healing for greater than 4 months

Nutritional status: Has consulted with nutritionist, currently eating heart healthy, high protein diet

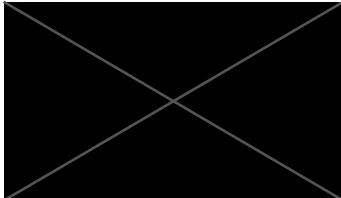
Contributing comorbidities: quadriplegia, chronic venous insufficiency, bed bound

Relevant FHx:

Mother: died at 92 yo, no known illness
Father: 70 yo, Hypertension, kidney disease
Brother: 72 yo, hypertension

Relevant PSHx:

Born in Montana, moved to Portland when she was 10
Married in 1978, 2 daughters, one in Oregon, one in Montana



Worked as Nike Global Safety Director, travelled extensively in Asia

Smoking history: Quit 2000, 10 pack year history

ETOH: None

Medications:

Arginine 1000 mg daily

Lasix 20 mg daily

Atorvastatin 80 mg daily

Baclofen 10 mg q 6 hrs for spasm

Bupropion 30 mg daily

Gabapentin 300 mg TID

Oxycodone 5 mg TID prn

Topamax 5 mg bid

Allergies:

Bactrim

ROS:

- General: denies chills, fever, fatigue
- Skin: Pressure ulcer of left lower extremity
- Respiratory: denies cough, SOB, wheezing
- Cardiovascular: denies chest pain, palpitations, edema
- Musculoskeletal: endorses weakness
- Neurological: endorses lack of mobility, depression

PE:

General: No acute distress

Skin: Sacral ulcer with undermining, LLE with pressure ulcer

Cardiovascular: no mrg

Respiratory: No rales, no ronchi, no wheezes

Studies:

QuantaFlow ABI: 3/19/2024 @ 10:30 AM PDT

Right Hand/Right Foot: 0.79 Mild (not usually reported as hemodynamically significant)

Left Hand/Left Foot: 1.04 Normal

-Bilateral lower extremity arterial duplex: performed at 7/28/2025 (Providence Medical Center)
Right: diffuse calcific plaque observed throughout the right lower extremity. Elevated velocity at the level of the right Mid SFA is suggestive of 50% stenosis.
Left: diffuse calcific plaque observed throughout the left lower extremity. Elevated velocity at the level of the left mid SFA is suggestive of 50-74% stenosis.

AS lower extremity arteries 4/15/22 (performed at Providence Medical Center)

Right SFA 30-44% stenosis (not hemodynamically significant)

Left SFA 50-74% stenosis (hemodynamically significant)

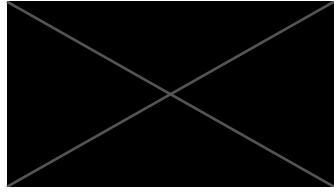
Mini Nutritional Assessment (nutritional status): 10

EXAM

Vital Signs:

T: 97.8 °F | HR: 74 bpm | RR: 12 rpm

Physical Exam:



9.7 x 5.5 x 1.0 cm (53.35 cm³) Denuded patches of dermal and subcutaneous tissue, involving Left Medial Lumbar Back - Lateral to L5

2.6 x 1.0 x 0.1 cm (0.26 cm³) Denuded patches of dermal and subcutaneous tissue, involving Left Lateral Lower Leg - Proximal

A&P

1. Pressure ulcer of back stage 4

- Problem: Chronic - Stable
- Morphology: Denuded patches of dermal and subcutaneous tissue (Left Medial Lumbar Back - Lateral to L5)
- Location(s): Left Lower Back
- - Stage: 4
- Wound Bed: Callus and biofilm
- Exudate Amount and Type: moderate serosanguinous
- Odor: mild
- Wound edge: rolled
- Peri-Wound Skin: Mild erythema, no warmth
- Wound Pain: 2/10
- MEDICAL NECESSITY: This chronic wound failed to meet expected healing goals despite standard wound care management (as outlined in the HPI). Any infectious process has been treated and the wound is free over overt signs of infection. Serial debridement was performed and clear granular tissue is noted throughout the wound bed. Moderate exudate from the wound bed is well controlled with the current dressing application which is designed to optimize healing environment and protect from trauma. Co-morbidities are well managed, nutritional and vascular status are being optimized as best as possible for this patient. Physical therapy has been working with patient in attempts to optimize offloading. With the clinical findings above and the previous lack of significant improvement of this chronic wound, it has been determined that this patient is medically eligible for advanced tissue placement.

Since the initiation of Simplimax biological tissue on December 10th, 2025, Colleen's wound has shown a 13% reduction in size.

Blood loss from today's wound debridement is estimated at less than 5 milliliters.

GOALS:

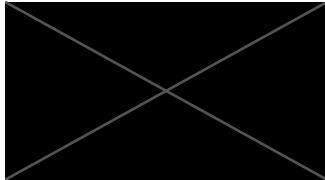
- Promote wound healing by reducing bacterial load and necrotic tissue.
- Manage biofilm, infection, and prevent further complications.
- Alleviate pain and discomfort associated with the wound.
- Improve patient mobility and overall quality of life.

OUTCOME MEASURES:

Photographs of the wound taken at each visit, demonstrating progressive healing.

Wound size and depth using a sterile ruler to be obtained at each visit.

- Plan:
 - Debridement (Open Wound): Left Medial Lumbar Back - Lateral to L5 · Preoperative Dimension(s): 9.7 x 5.5 x 1.0 cm (53.35 cm³) · Postoperative Dimension(s): 9.9 x 5.7 x 1.2 cm (67.72 cm³) · Procedure description: Prior to procedure the treatment site was clearly identified by the patient / caregiver(s). All components of the Universal Protocol / PAUSE Rule completed. The wound was cleansed and anesthetized with Lidocaine HCl 2% (as indicated for pain management) and irrigated with Puracyn and sterile saline. Debridement was performed using a combination of sterile 15 blade, iris scissors, forceps and curettage to remove all non-viable and / or necrotic tissue until a clean wound base was revealed. Hemostasis was achieved using 20% aluminum chloride focally for any persistent



oozing when necessary. The patient tolerated the procedure well.

- Application Of Skin Substitute Graft: Left Medial Lumbar Back - Lateral to L5 · Preoperative Dimension(s): 9.9 x 5.7 x 1.2 cm (67.72 cm³) · Procedure description: Prior to procedure the treatment site was clearly identified by the patient/caregiver(s). All components of the Universal Protocol/PAUSE Rule completed. After anesthesia and debridement, antimicrobial gel (Puracyn or Vashe) was applied to the wound base to discourage bacterial infection. This was followed by careful application of SimpliMax Amniotic Membrane Allograft skin substitute to the open wound site. The application of Simplimax is medically necessary to act as a scaffolding for the migration and adhesion of new cell growth for repair and replacement of the injured tissue and to stimulate new tissue growth. The product was applied for intimate contact with the wound bed conforming to wound depth, undermining and contours. This was followed by the proper combination of an Adaptic dressing (to help protect the wound while preventing the dressing from adhering to the wound itself) followed by a dry, sterile collagen dressing or a super absorbent foam dressing to provide anti-infective, anti inflammatory and analgesic properties as well as to promote angiogenesis. Sterile telfa was added for non-adherent padding and protection of the wound site. Sterile gauze to ensure absorption of any drainage as well as provide padding and protection of the skin of the wound and surrounding skin. Two-Press compression dressing (if appropriate for wound site) to provide sustained compression for optimal blood flow and healing. The patient tolerated the procedure well. The patient will be seen during a follow-up visit in one week for potential reapplication of SimpliMax Amniotic Membrane Allograft skin substitute if needed. Post procedure instructions were reviewed in detail with the patient/caregiver(s).

MULTI-WOUND DISTRIBUTION CHART

*Biologic Regenerative Graft: Simplimax

Wound #1: 54 units

Graft #1 of 4

Graft Size: 4x8

Tissue ID: 637331003

Expiration: 11/05/2028

Units placed: 32

Units Wasted: 0

Total Units: 32

Graft #2 of 4

Graft Size: 4x4

Tissue ID: 593959008

Expiration: 07/22/2028

Units placed: 16

Units Wasted: 0

Total Units: 16

Graft #3 of 4

Graft Size: 2x3

Tissue ID: 601426006

Expiration: 08/07/2028

Units placed: 6

Units Wasted: 0

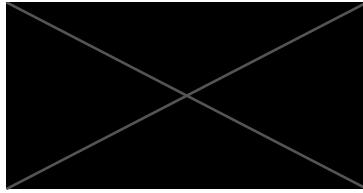
Total Units 6

Wound #2: 3 units

Graft #4 of 4

Graft Size: 2x3

Tissue ID: 596571012



Expiration: 07/27/2028

Units placed: 3

Units Wasted: 3

Total Units: 6

Total Units Placed: 57

Total Units Wasted: 3

Total Units for Visit: 60

2. Pressure ulcer of left lower leg stage 4

- Problem: Chronic - Stable
- Morphology: Denuded patches of dermal and subcutaneous tissue (Left Lateral Lower Leg - Proximal)
 - Body Surface Area (BSA): 0.6 %
 - Location: Left Lateral Lower Leg - Proximal
 - - Stage: 4
 - Wound Bed: Callus and biofilm
 - Exudate Amount and Type: moderate serosanguinous
 - Odor: None
 - Wound edge: Well defined
 - Peri-Wound Skin: warm, dry, pink, mild scaling
 - Wound Pain: 3/10
 - MEDICAL NECESSITY: This chronic wound failed to meet expected healing goals despite standard wound care management (as outlined in the HPI). Any infectious process has been treated and the wound is free over overt signs of infection. The wound has undergone serial debridement and clear granular tissue is noted throughout the wound bed. Moderate exudate from the wound bed is well controlled with the current dressing application which is designed to optimize healing environment and protect from trauma. Co-morbidities are well managed, nutritional and vascular status are being optimized as best as possible for this patient. Physical therapy has been working with patient in attempts to optimize offloading. With the clinical findings above and the previous lack of significant improvement of this chronic wound, it has been determined that this patient is medically eligible for advanced tissue placement.

Since the initiation of Simplimax biological tissue on December 10th, 2025, Colleen's wound has shown a 11% reduction in size.

Blood loss from today's wound debridement is estimated at less than 5 milliliters.

GOALS:

Promote wound healing by reducing bacterial load and necrotic tissue.

Manage biofilm, infection, and prevent further complications.

Alleviate pain and discomfort associated with the wound.

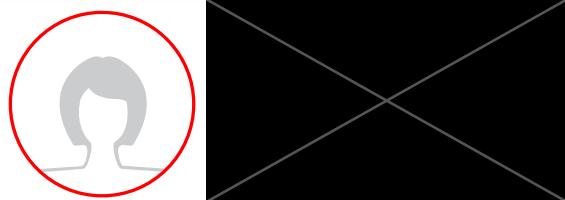
Improve patient mobility and overall quality of life.

OUTCOME MEASURES:

Photographs of the wound taken at each visit, demonstrating progressive healing.

Wound size and depth using a sterile ruler to be obtained at each visit.

- Plan:
 - Debridement (Open Wound): Left Lateral Lower Leg - Proximal · Preoperative Dimension(s): 2.6 x 1.0 x 0.1 cm (0.26 cm³) · Postoperative Dimension(s): 2.7 x 1.1 x 0.1 cm (0.30 cm³) · Procedure description: Prior to procedure the treatment site was clearly identified by the patient / caregiver(s). All



components of the Universal Protocol / PAUSE Rule completed. The wound was cleansed and anesthetized with Lidocaine HCl 2% (as indicated for pain management) and irrigated with Puracyn and sterile saline. Debridement was performed using a combination of sterile 15 blade, iris scissors, forceps and curettage to remove all non-viable and / or necrotic tissue until a clean wound base was revealed. Hemostasis was achieved using 20% aluminum chloride focally for any persistent oozing when necessary. The patient tolerated the procedure well.

- Application Of Skin Substitute Graft: Left Lateral Lower Leg - Proximal · Preoperative Dimension(s): 2.7 x 1.1 x 0.1 cm (0.30 cm³) · Procedure description: Prior to procedure the treatment site was clearly identified by the patient/caregiver(s). All components of the Universal Protocol/PAUSE Rule completed. After anesthesia and debridement, antimicrobial gel (Puracyn or Vashe) was applied to the wound base to discourage bacterial infection. This was followed by careful application of SimpliMax Amniotic Membrane Allograft skin substitute to the open wound site. The application of Simplimax is medically necessary to act as a scaffolding for the migration and adhesion of new cell growth for repair and replacement of the injured tissue and to stimulate new tissue growth. The product was applied for intimate contact with the wound bed conforming to wound depth, undermining and contours. This was followed by the proper combination of an Adaptic dressing (to help protect the wound while preventing the dressing from adhering to the wound itself) followed by a dry, sterile collagen dressing or a super absorbent foam dressing to provide anti-infective, anti inflammatory and analgesic properties as well as to promote angiogenesis. Sterile telfa was added for non-adherent padding and protection of the wound site. Sterile gauze to ensure absorption of any drainage as well as provide padding and protection of the skin of the wound and surrounding skin. Two-Press compression dressing (if appropriate for wound site) to provide sustained compression for optimal blood flow and healing. The patient tolerated the procedure well. The patient will be seen during a follow-up visit in one week for potential reapplication of SimpliMax Amniotic Membrane Allograft skin substitute if needed. Post procedure instructions were reviewed in detail with the patient/caregiver(s).

*Biologic Regenerative Graft: Simplimax
See Multiwound Distribution Chart Above

Order of dressings to be changed as often as every other day. Change outer dressing starting with adaptic layer outward. DO NOT DISTURB GRAFT. *Primary: Adaptic *Secondary: Telfa or non-adherent pad *Secondary: Cover with an ABD pad and secure with stretch gauze.

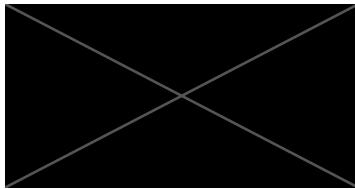
Pressure ulcer of left lower leg stage 4

Patient education:

- Home Health Orders:

Wound #1 Pressure ulcer of lower back

1. A biologic regenerative tissue graft has been applied to the wound beds of the left lower extremity. The inner non-stick petroleum infused silicone dressing (Adaptic) and graft should be left undisturbed for 5 days for optimal healing.
2. Check daily to ensure that the outer dressing is clean and dry.
- If it is saturated and draining, replace it (without disturbing the inner petroleum dressing and graft).
3. If the petroleum dressing (Adaptic) and biologic graft is removed accidentally prior to our next scheduled visit. Cleanse the wound with a non-cytotoxic wound cleanser such as vase, puracyn plus.
4. Gently place a fresh Adaptic or petroleum infused silicone dressing to the wound bed.
5. Apply a super absorbent silicone sacral dressing as an outer layer

**Wound #2 Pressure ulcer of left lower extremity**

1. A biologic regenerative tissue graft has been applied to the wound beds of the left lower extremity. The inner non-stick petroleum infused silicone dressing (Adaptic) and graft should be left undisturbed for 5 days for optimal healing.
2. Check daily to ensure that the outer dressing is clean and dry.
- If it is saturated and draining, replace it (without disturbing the inner petroleum dressing and graft).
3. If the petroleum dressing (Adaptic) and biologic graft is removed accidentally prior to our next scheduled visit. Cleanse the wound with a non-cytotoxic wound cleanser such as vase, puracyn plus.
4. Gently place a fresh Adaptic or petroleum infused silicone dressing to the wound bed.
5. Cover with a secondary dressing that is appropriate to manage the level of exudate such as Telfa
6. Apply an ABD pad and secure with roll gauze.

The wet to dry method is not a preferred treatment. Moist wound healing is preferred for optimal outcome. Watch for signs of infection including but not limited to: fever, increased pain, increased wound odor, or excessive wound oozing, or change in mental status.

Treatment Plan:

Wound care to be performed by AWCH on Wednesdays and Providence Home Health on Mondays. Weekly follow-up visits for wound assessment, infection monitoring, and adjustment of treatment as necessary.

Please feel free to contact me with any questions,
Lionel Marx PA-C, WCC

Patient-Specific Instructions:

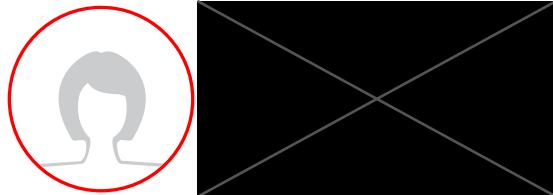
1. When in bed, reposition every 90 minutes and use wedges and pillows to offload pressure from wounds and heel areas.
2. Elevate legs whenever sitting for more than 10 minutes
3. Follow a high-protein, calorie-dense nutrition plan with supplementation of essential vitamins (Vitamin C, zinc, arginine) to support wound healing. Nutritional status will be monitored and adjusted based on the patient's needs.
4. Smoking cessation: Patient does not smoke.
5. Change the dressing daily or when soiled.

Chronic wound

Patient education: A biologic regenerative tissue graft has been applied to the wound bed. The inner non-stick petroleum gauze (Adaptic or xeroform) and graft should be left undisturbed for 5-7 days for optimal healing.

Wound Care:

- 1) Keep the bandage clean and dry. A biologic sheet has been applied to the wound bed, the inner bandage and sheet should remain undisturbed for 5-7 days for optimal healing.
- 2) Bandages/supplies for wound treatment will or have been shipped to the residence. If replacement of bandages is necessary before your provider returns, first, wash your hands. Then use the provided



supplies to dress your wounds.

- 3)Check outer bandages daily to ensure they are clean, intact and dry. Change any wet or soiled dressings without disturbing the inner bandage.
- 4)If the biologic sheet is removed prior to the provider's next scheduled visit, record the date, take a photo of the wound if possible, clean and bandage the wound with provided supplies and notify our office immediately so that we may document this in the patient's chart.
- 5)Watch for signs of infection including but not limited to: fever, increased pain, increased redness of the wound, increased odor or discharge, change in patient's mental status. Contact the patient's primary care provider or seek in person care for any new or worsening symptoms or sign of infection as soon as they are noted.

Infection Control:

1. Daily dressing checks will be performed by the caregiver.
2. Caregiver has been instructed on changing soiled dressings and monitoring for signs of infection, such as fever, increased pain, or excessive wound drainage.

Off-Loading and elevation:

1. When in bed, reposition every 90 minutes and use wedges and pillows to offload pressure from wounds and heel areas.
2. Elevate legs whenever sitting for more than 10 minutes

Diet:

Chronic wounds require calories, protein and vitamins to heal. Follow a high-protein, calorie-dense nutrition plan with supplementation of essential vitamins(Vitamin C, zinc, arginine) to support wound healing.

Other instructions:

Do not smoke. Smoking dries out the skin, reduces blood flow to the skin and slows healing. If you need help quitting, talk to your doctor about stopping smoking programs and medication options. These can increase your chances of quitting for good.

Outcome Management:

Photographs of the wound will be taken at each visit, demonstrating progressive healing. Outcome Management:

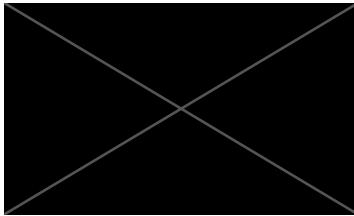
Wound size and depth using a sterile ruler to be obtained at each visit

Patient will be seen weekly for wound assessments, infection monitoring and adjust of treatment as necessary. 10 weeks of therapy will be completed and then plan reassessed. Instructions for caregiver(s) to check bandage daily and reinforce or change secondary dressing if it becomes loose or there is excess drainage.

Comorbidity Management:

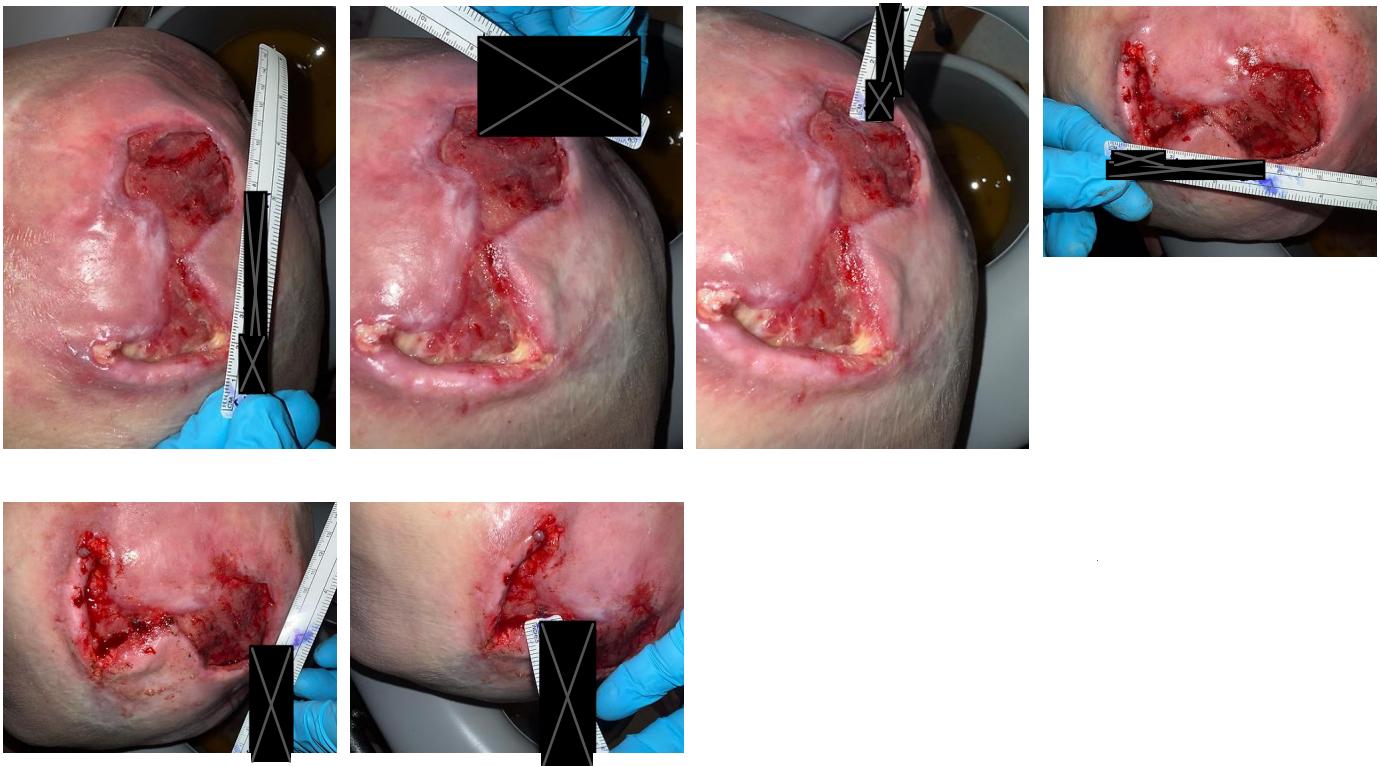
The patient's PCP will continue to manage the patient's health including multiple sclerosis, CHF, chronic pain and advise on wound care.

The risks, benefits and alternatives to therapy were discussed in detail. Specifically, the risks of infection, scarring, bleeding, prolonged wound healing, incomplete wound healing, allergy to anesthesia, nerve injury and recurrence were addressed.



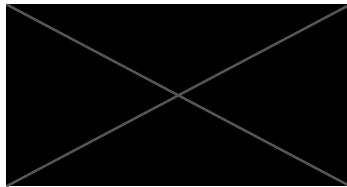
IMAGES

Pressure ulcer of back stage 3



Pressure ulcer of left lower leg stage 4





Electronically signed by Lionel Marx, PA-C on 01-01-2026 at 07:11:23 PM PST
Electronically cosigned by Mark Kaufmann, MD on 01-02-2026 at 07:49:40 AM PST
Care Team:
Lionel Marx, PA-C, primary provider