

FAX COVER SHEET**MUNSON HEALTHCARE**

PLEASE DELIVER TO: ATTN: Nick DATE: 8/25/2025 3:49:48 PM
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GRAHAM, Lawrence DOB: 02/05/1957 (66 yo M) Acc No. 91165 DOS: 01/30/2024



Graham, Lawrence

66 Y old Male, DOB: 02/05/1957

Account Number: 91165

2121 W US Highway 10, Ludington, MI-49431

Home: 231-690-3952

Guarantor: Graham, Lawrence Insurance: PRIORITY

HEALTH MEDICARE Payer ID: C7459

PCP: Allan Nelson

Appointment Facility: MHM Wound and Hyperbaric

01/30/2024

Progress Notes: Elizabeth Foster

Current Medications

Taking

- hydroCHLORothiazide 12.5 MG Tablet 1 tablet Orally Once a day
 - Benadryl 25 MG Tablet 1 tablet at bedtime as needed Orally Once a day
 - Lidocaine HCl 4 % Cream as directed Externally with dressing changes
 - Metoprolol Succinate ER 25 MG Tablet Extended Release 24 Hour 1 tablet Orally Once a day
 - aspirin 81 mg 1 daily
 - Meloxicam 15 MG Tablet 1 tablet Orally Once a day
 - Cyanocabalamin 1000 MCG/15ML Liquid 15 mL Orally Once every 3 months
 - Vitamin D 3 1000 IU Soft Gel 1tablet PO Once a day
 - Magnesium 400 MG Capsule 1 tablet with a meal Orally Once a day
 - Atorvastatin Calcium 80 MG Tablet 1 tablet Orally Once a day
 - Clobetasol Propionate 0.05 % Ointment 1 application Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Back Trouble: Disc.
Sleep Apnea / CPAP.
Claustrophobia.
High Cholesterol.
Leg Ulcer.

Surgical History

cataract surgery
Hernia Surgery - 1957 & 2002
Colonoscopy- 2007, 2017 & 2022
heart catheterization 06/23
vein ablation on the left lower extremity 8/17/23

Family History

Father: deceased
Mother: alive

Reason for Appointment

1. Left lower leg chronic ulcer

History of Present Illness

Wound care:

This 66 year old male presents today for followup, evaluation and management of non-healing stasis ulcers to LLL. Pt reports the wounds started in October 2022 and he's been seeing Dr. Richley for treatment with Mupirocin ointment. States he does normally wear compression on a daily basis. Pt has Hx of compound fracture to LLL in 2006 and has had wounds on LLL in the past that reportedly took over a year to heal. Pt has been using an other the counter bacitracin/zinc ointment which has helped. Patient had another vein procedure (sclerotherapy) done on 10/12/23. No acute concerns in regards to wound care at today's encounter.

1/30/24 Pt reports his leg started getting irritated around the wound and he started the Clobetasol to the surrounding the skin.

Vital Signs

BP: **128/60 mm Hg**, Ht: 71 in, Ht-cm: 180.34 cm, Wt: **269.5 lbs**, Wt-kg: **122.24 kg**, BMI: **37.58 Index**, Temp: **98.0 F**, HR: **72 /min**, RR: **18**, Oxygen sat %: **96 %**, Pain scale: **0 1-10**.

Examination

Wound Care::

Wound 1
Wound Type *stasis ulcer*
Wound Location *LLL lateral distal*
Epithelialization Pre procedure *Large 67-100%*
Wound Status *stable, improved*
Classification *Full thickness without exposed support structure*
Signs of Infection *no*
Exudate Amount *None present*
Foul Odor after Cleansing *No*
Texture *No Abnormality*
Moisture *No Abnormality*
Color *No Abnormality*
Temperature *No Abnormality (Patient Warm)*
Tenderness on Palpation *No*

General Examination:

GENERAL APPEARANCE: Alert and no acute distress. Well

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Daughter(s): alive
 Son(s): alive
 Paternal Grand Father: deceased
 Paternal Grand Mother: deceased
 Maternal Grand Father: deceased
 Maternal Grand Mother: deceased
 Siblings: alive
 2 brother(s), 6 sister(s), 2 son(s), 1 daughter(s).
 Family History of Heart Disease and Diabetes.

Social History

Abuse and Neglect Screen:

Abuse and Neglect Screen
 Screening Date: 01/15/2024
 Do you ever feel unsafe in your home or neighborhood? No
 Information Obtained From:

Patient

Type of visit: Established Patient
 Has anyone physically harmed you?
 No
 Has anyone emotionally harmed you? No
 Is there anyone you are uncomfortable being around? No
 Do you have any family/friends that abuse drugs or alcohol? No
 Does anyone force you to do things you do not want to do? No
 Is there someone who takes your things without permission? No

Allergies

Band-Aid: skin irritation
 Lisinopril: Anaphylaxis - Allergy - Criticality High - Onset Date 07/02/2023
 Bee Sting: Anaphylaxis - Allergy - Criticality High - Onset Date 07/02/2023

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Denies Chills. Denies Fever.

Allergy/Immunology:

Admits Blistering of skin.

Endocrine:

Denies Frequent urination.

Respiratory:

Shortness of breath Denies Cough.

Cardiovascular:

Chest pain Denies Palpitations.

Gastrointestinal:

Denies Abdominal pain.

Genitourinary:

Denies Blood in urine.

Denies Difficulty urinating.

nourished, well developed.

HEAD: Normocephalic, face symmetric.

EYES: Conjunctiva clear, no discharge.

NOSE: Nares patent, no discharge.

CARDIAC: Regular rate and rhythm..

LUNGS: normal respiratory effort.

MUSCULOSKELETAL: Normal strength and tone..

Extremities Trace pitting edema lower extremities.

PERIPHERAL PULSES: Good capillary refill.

NEUROLOGIC: Alert and Oriented.

PSYCH: Mood/affect within normal limits.

SKIN: **No rashes.**

WOUND See wound care documentation.

Assessments

1. Chronic venous hypertension (idiopathic) with ulcer of left lower extremity - I87.312 (Primary)
2. Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed - L97.822
3. Other atopic dermatitis - L20.89
4. Dietary counseling and surveillance - Z71.3

Treatment

1. Chronic venous hypertension (idiopathic) with ulcer of left lower extremity

Notes: Patient with a history of venous stasis edema to bilateral lower extremities. Patient has since had multiple encounters with vascular for sclerotherapy to veins in left lower leg.

2. Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed

Notes: Upon evaluation at today's encounter, patient has stable chronic ulcer noted to the left lower extremity which is healed. I discussed with patient and significant other the plan of care to be as follows and both agreeable. No further dressings required at this time, can leave open to air. Discussed with patient to utilize clobetasol to the red irritated area twice daily until resolved and then can use as needed. No future appointment required at this time unless questions or concerns arise. Patient and significant other both state understanding and agree with this plan of care, all questions asked at today's encounter were answered.

3. Other atopic dermatitis

Notes: Improvements in erythema to the surrounding tissue. Patient states understanding and agrees with this plan of care.

4. Dietary counseling and surveillance

Notes: Reiterated the importance of supplementation of protein in diet during wound and/or ulcer healing time period. Discussed with patient during this healing process additional supplementation of protein may be needed to ensure patient reaches their goal of 1 gram per kilogram of body weight. Encouraged patient to refer back to handouts provided which included supplemental protein foods to continue/add into diet.

Procedures

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Musculoskeletal:

Denies Assistive Devices.
Admits Painful joints.

Peripheral Vascular:

Denies Decreased sensation in extremities.

Skin:

Rashes Denies. Admits Ulcers.

Wound Care:

Wound 1: LLL lateral distal.

Wound Debridement

Wound Condition: *Stable Chronic*

Wound Size: *Healed*

Type of Debridement: *No debridement required*

Dressing: *Applied Eucerin lotion to leg. Pt to use Clobetasol to site 2 x daily to help minimize redness and irritation. No dressings needed.*

Compression: *Pt to wear his own compression*

Return Visit: *No further visits as needed*

Procedure Codes

99212 OFFICE VISIT, FAC FEE, EST PT, LEVEL 2

99212 OFFICE VISIT, PROF FEE, EST PT, LEVEL 2

Follow Up

prn (Reason: future wound care needs)

Images

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**Electronically signed by Elizabeth Foster on 01/30/2024 at
11:43 AM EST**

Sign off status: Completed

**MHM Wound and Hyperbaric
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