FAX COVER SHEET

MUNSON HEALTHCARE

PLEASE DELIVER TO:	ATTN: Nick	**DATE:**	8/25/2025 3:50:40 PM
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SUBJECT:			

The following document(s) are transmitted for delivery to the above named individual and consist of 7 page(s), including the cover sheet.

NOTES:

If you have any questions, please contact the above sender.

1105 Sixth Street
Traverse City, Michigan
49684-2386
(231) 935-5000

GRAHAM, Lawrence **DOB:** 02/05/1957 (68 yo M) **Acc No.** 91165 **DOS:** 08/08/2025

MUNSON HEALTHCARE

Graham, Lawrence

68 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

08/08/2025 **Progress Notes: Elizabeth Foster**

Current Medications

Taking

- Ezetimibe 10 MG Tablet 1 tablet Orally Once a day
- Ambien(Zolpidem Tartrate) 5 MG Tablet 1 tablet at bedtime as needed Orally Once a day
- hydroCHLOROthiazide 12.5 MG Tablet 2 tablets Orally Once a day
- Benadryl 25 MG Tablet 1 tablet at bedtime as needed Orally Once a day
- Metoprolol Succinate ER 25 MG Tablet Extended Release 24 Hour 1 tablet Orally Once a day
- asprin 81 mg 1 daily
- Meloxicam 15 MG Tablet 1 tablet Orally Once a day
- Cyanocobalamin 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

Discontinued

- Lidocaine HCl 4 % Cream as directed Externally with dressing changes Medication List reviewed and reconciled with the patient

Past Medical History

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

Surgical History

Reason for Appointment

1. (new wound) Left leg Ulcers

History of Present Illness

Depression Screening:

PHQ-9

Little interest or pleasure in doing things *Not at all*
Feeling down, depressed, or hopeless *Several days*
Trouble falling or staying asleep, or sleeping too much *More than half the days*
Feeling tired or having little energy *More than half the days*
Poor appetite or overeating *Not at all*
Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Not at all*
Trouble concentrating on things, such as reading the newspaper or watching television *Not at all*
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Not at all*
Thoughts that you would be better off dead or of hurting yourself in some way *Not at all*
Total Score *5*
Interpretation *Mild Depression*

Depression Screening:

PHQ-2 (2015 Edition)

Little interest or pleasure in doing things? *Not at all*
Feeling down, depressed, or hopeless? *Several days*
Total Score *1*

Wound care:

This 68 year old here today with his spouse, Susan and presents today for evaluation and management of non-healing stasis ulcers to LLL. Pt reports the wound occurred when he scraped his leg on 6/20/25 on his luggage while traveling and was using Bacitracin to area with dry dressing. Pt saw his PCP Dr. Cooney on 7/28/25 and was referred here. Pt is now using Zinc to area twice a day and dry dressing. Pt does wear his compression daily. Pt reports he did go swimming in a pool yesterday with no dressing. Pt has Hx of compound fracture to LLL in 2006 and has had wounds on LLL in

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cataract surgery
Hernia Surgery - 1957 & 2002
Colonoscopy- 2007, 2017 & 2022
heart catherization 06/23
vein ablation on the left lower extremity 8/17/23
Hernia Surgery 5/22/24
L Knee replacement part 1 6/11/2024
L Knee Replacement part 2 1/14/2025
R Hip 3/18/2025

Family History

Father: deceased
Mother: alive
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: *08/08/2025*
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*
Tobacco Use:
Tobacco Use/Smoking
Are you a *nonsmoker*
Screening performed
Date *08/08/2025*
Drugs/Alcohol:
Drugs
Have you used drugs other than those for medical reasons in the past 12 months? *Yes*
Marijuana? *Yes*
Alcohol Screen
Did you have a drink containing alcohol in the past year? *Yes*
How often did you have a drink containing alcohol in the past year?

the past that reportedly took over a year to heal. Patient most recent vein procedure (sclerotherapy) done on 10/12/23. Pt had left TKA in June 2024, and it became infected, in November had an antibiotic spacer placed, and in January 2025 had a new replacement surgery. Pt had THA o R hip in March 2025.

Vital Signs

BP: **110/64 mm Hg**, Ht: 71 in, Ht-cm: 180.34 cm, Wt: **254.9 lbs**, Wt-kg: **115.62 kg**, BMI: **35.55 Index**, Temp: **98.0 F**, HR: **78 /min**, RR: **16**, Oxygen sat %: **94 %**, Pain scale: **6 1-10**.

Examination

Wound Care::
Wound 1
Wound Location *Left lateral lower leg clusters*
Epithelialization Pre procedure *None Present*
Epithelialization Post procedure *None Present*
Tunneling *No*
Undermining *No*
Classification *Full thickness without exposed support structure*
Signs of Infection *no*
Exudate Amount *Medium*
Exudate Type *Serosanguineous*
Foul Odor after Cleansing *No*
Wound Margin *Distinct, outline attached*
Slough/Fibrin *Yes*
Necrotic Type *Yellow Fibrin/Slough, Wet/Hydrated*
Texture *Localized Edema*
Moisture *No Abnormality*
Color *Hemosiderin Staining*
Temperature *No Abnormality (Patient Warm)*
Tenderness on Palpation *No*

General Examination:
GENERAL APPEARANCE: Alert and no acute distress. Well 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

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4 or more times a week (4 points)
How many drinks did you have on a typical day when you were drinking in the past year? *3 or 4 drinks (1 point)*
How often did you have 6 or more drinks on one occasion in the past year? *Weekly (3 points)*
Points *8*
Interpretation *Positive*
Alcohol Counseling Performed
Date performed: *01/15/2024*

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

Surgeries Above

Review of Systems

General/Constitutional:
Denies Chills. Denies Fever.
Allergy/Immunology:
Admits Blistering of skin.
Admits Itching.
Endocrine:
Denies Frequent urination.
Respiratory:
Shortness of breath Denies.
Denies Cough.
Cardiovascular:
Chest pain Denies.
Denies Palpitations.
Gastrointestinal:
Denies Abdominal pain.
Denies Blood in stool.
Genitourinary:
Denies Blood in urine.
Denies Difficulty urinating.
Musculoskeletal:
Denies Assistive Devices.
Admits Painful joints.
Peripheral Vascular:
Denies Decreased sensation in extremities.
Skin:
Rashes Denies. Admits Ulcers.

2. Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed - L97.822 (Primary)
3. Dietary counseling and surveillance - Z71.3
4. Other specified counseling - Z71.89

Treatment

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

Notes: Upon evaluation at today's encounter, patient with what previously stated as a laceration has now progressed into chronic ulcers clustered noted to the left lower extremity. Edges are distinct outlined flat and intact. No obvious odors or signs of infection. Moderate amount of serosanguineous drainage present. Thick layer of nonviable slough noted. I discussed with patient and significant other the plan of care to be as follows and both agreeable. We will perform debridement to remove nonviable tissue as described in procedure section. Patient requesting to continue to utilize zinc paste at this time as a primary dressing, secured with secondary dressing as described in procedure section. Patient to perform dressing changes daily and as needed and follow-up in 2 weeks. Patient to continue to utilize his own compression daily. Discussed with patient to avoid submersion or soaking in water, as he went swimming in a pool yesterday. Limiting factors that impact healing based on patient's clinical history are chronic venous insufficiency, recurrent cellulitis, previous history of difficult to healing ulcers, eczema exacerbation to surrounding tissue, age, compliance with plan of care. Based on these factors, potential to heal is moderate. Will have a goal of 20% reduction in ulcer size by 8 weeks (Oct 3, 2025). Patient and significant other both state understanding and agree with this plan of care, all questions asked at today's encounter were answered. Encouraged patient to call with questions or concerns prior to next appt.

2. 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.

3. 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.

4. Other specified counseling

Notes: If applicable, educated patient nonhealing wounds/ulcers can be impacted by trauma, surgery, persistent pressure to area, infection, vascular insufficiency, systemic and autoimmune

disorders, foreign material, certain medications, malignancy, etc. Management of chronic wounds and ulcers includes but not limited to debridement, optimal moisture environment to area of injury, management of co-morbidities, pressure reduction and offloading of area of injury, prevention and treatment of infection, improving venous and arterial circulation if possible, refraining from all nicotine products. Discussed the goals of debridement are to remove devitalized tissue, decrease risk of infection, promote wound healing and prevent further complications. Also discussed risk and benefits of advanced wound care were discussed with the patient. The benefits include enhancing wound/ulcer healing and improving the patient's quality of life. The potential risk includes mild to moderate pain with debridement, a risk of infection to the wound/ulcer and the potential that the wound/ulcer could deteriorate or not heal. The patient understands that wound/ulcer sometimes herald significant changes and may necessitate surgery or amputation during treatment. The need for periodic debridement, wound cultures or biopsies and serial digital photography to document progress of the wound/ulcer was also discussed. Also discussed that there is no guarantee we will get full closure of the injured area by secondary or tertiary healing. The healing process is impacted by many factors discussed above, and to optimize healing, there will need to be compliance with recommended treatment. The patient expresses understanding of the discussion and once given opportunity to ask questions answered. Verbal acknowledgment of this understanding and consent prior to treatment was obtained.

Discussed with patient clinical signs of wound infection that might warrant antibiotic therapy include local (cellulitis, streaking, purulence, malodor, wet gangrene, osteomyelitis) and systemic (fever, chills, nausea, hypotension, hyperglycemia, change in mental status) symptoms. Discussed with patient if any of these occur, call our office or go to emergency room.

Procedures

Wound Care:

Wound 1: Left lateral lower leg cluster.

Wound Debridement

Wound Size: *Length=4.7 cm x Width=9.8 cm x Depth=0.1 cm*

Anesthetic: *Topical lidocaine 2%*

Type of Debridment: *excisional*

Cutting Instrument: *currette*

Deepest Layer of Tissue Removed: *subcutaneous*

Description of Tissue Removed: *slough, exudate, viable, non viable, devitalized, fibrin*

Viable Bleeding Tissue Encountered: *Yes*

Pain Control: *Good, Patient reports no significant pain*

Initial Wound Debridement: *Yes*

Wound Size Post Procedure: *Length= cm x Width= cm x Depth= cm*

Secondary dressing *Cover with 4x4, wrap lightly with Kerlix rolled gauze and secure with tape*

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Dressing change frequency *Twice a day*
Compression: *Patient to use own compression stockings*
Return Visit: *Two weeks*

Actual Procedure A timeout was conducted with the patient prior to the start of the procedure. , Informed consent was obtained from the patient. , Anesthesia was applied to the wound. , After waiting 10 minutes for the anesthetic to take effect, the procedure was initiated , Sharp debridement was carried up to and including, the deepest layer indicated above. , The wound was sharply debrided using the aforementioned instrument(s). , Nonviable tissue in the following form(s) was removed and discarded: , exudate , Devitalized , biofilm , slough , Viable tissue was removed in the following form(s): , Subq. , Bleeding was controlled by the following method(s): , direct pressure.

Preventive Medicine

Nutrition:
Nestle Nutrition
Malnutrition Screening (MNA) *Yes*
Has you food intake declined over the past 3 months? *2 = no decrease in food intake*
How much weight have you lost in the last three months? *3 = no weight loss or weight loss less than 2 pounds*
How would you describe your current mobility? *2 = able to leave my home*
Have you been stressed or severely ill in the past 3 months? *0 = yes*
Are you currently experiencing dementia and/or prolonged severe sadness? *2 = neither dementia nor prolonged severe sadness*
Score: *9*

Screening/Special Tests:
Fall Risk Screening
Date of Fall Risk Assessment *08/08/2025 See document scanned in patient chart*

Procedure Codes

11042 debride skin/tissue fac fee
11042 debride skin/tissue prof fee
99213 OFFICE VISIT, FAC FEE, EST PT, LEVEL 3
99213 OFFICE VISIT, PROF FEE, EST PT , LEVEL 3 assessing and addressing plan of care of new ulcers left lower leg

Follow Up

2 Weeks (Reason: f/u left lower leg ulcers)

Images

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Progress Note: Elizabeth Foster 08/08/2025

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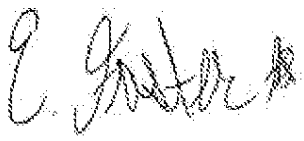

Electronically signed by Elizabeth Foster , NP on 08/08/2025 at 10:03 AM EDT

Sign off status: Completed

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Progress Note: Elizabeth Foster 08/08/2025

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