FAX COVER SHEET

MUNSON HEALTHCARE

PLEASE DELIVER TO:	ATTN: Nick	**DATE:**	8/25/2025 3:48:48 PM
RECIPIENT'S PHONE:		**FAX:**	918593996697
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SUBJECT:			

The following document(s) are transmitted for delivery to the above named individual and consist of 8 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 (66 yo M) **Acc No.** 91165 **DOS:** 12/12/2023

MUNSON HEALTHCARE

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

12/12/2023 **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
- 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

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 catherization 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

Depression Screening:

PHQ-9

Little interest or pleasure in doing things *Not at all*
Feeling down, depressed, or hopeless *Not at all*
Trouble falling or staying asleep, or sleeping too much *Not at all*
Feeling tired or having little energy *Not at all*
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 *0*

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.

11/8/23 Pt reports he has appointment with Cardiologist 11/22/23 for annual follow up and appointment with Vein Specialist on 11/28/23.

12/12/23 Pt reports he started developing a rash around the wound after using the Mupirocin and stopped the Mupirocin and went back to using the bacitracin with zinc in it.

Vital Signs

BP: **137/76 mm Hg**, Ht: 71 in, Ht-cm: 180.34 cm, Wt: **261.0 lbs**, Wt-kg: **118.39 kg**, BMI: **36.40 Index**, Temp: **98.7 F**, HR: **83 /min**, RR: **17**, Oxygen sat %: **97 %**, Pain scale: **0 1-10.**

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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: *12/12/2023*
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 *12/12/2023*
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? *2 to 3 times a week (3 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? *Less than monthly (1 point)*
Points *5*
Interpretation *Positive*
Alcohol Counseling Performed
Date performed: *12/12/2023*

Allergies

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

Examination

Wound Care::
Wound 1
Wound Type *stasis ulcer*
Wound Location *LLL lateral distal*
Epithelialization Pre procedure *Large 67-100%*
Wound Status *stable, improved*
Tunneling *No*
Undermining *No*
Classification *Full thickness without exposed support structure*
Signs of Infection *no*
Exudate Amount *Small*
Exudate Type *Serosanguineous*
Foul Odor after Cleansing *No*
Wound Margin *Distinct, outline attached, Flat & Intact*
Slough/Fibrin *Yes*
Granulation Amount (%) *90*
Granulation Quality *Red, Pink*
Necrotic Amount (%) *10*
Necrotic Type *Yellow Fibrin/Slough*
Texture *No Abnormality*
Moisture *No Abnormality*
Color *No Abnormality*
Temperature *No Abnormality (Patient Warm)*
Tenderness on Palpation *No*

Wound 1 Size Length= 0.2cm x Width= 0.1cm x Depth= 0.1cm .

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 (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

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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. 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.

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 has slight improvements in epithelial tissue forming at the edges. Edges are distinct outlined flat and intact. No obvious odors or signs of infection. Small amount of serosanguineous drainage present. No obvious odors or signs of infection present. I discussed with patient and significant other the plan of care to be as follows and both agreeable. We will perform mechanical debridement with nonviable tissue as described in procedure section. Patient requesting to continue to utilize bacitracin/zinc as a primary dressing since starting it has improved, secured with secondary dressing as described in procedure section. Patient to perform dressing changes daily and follow-up in 3-4 weeks. Patient to continue to utilize his own compression daily. 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. Based on these factors, potential to heal is moderate. Met previous goal with 87% reduction in wound size, will have an updated goal of 25% reduction in ulcer size by 6 weeks (Dec 27, 2023). patient and significant other both state understanding and agree with this plan of care, all questions asked at today's encounter were answered. Encourage patient to call with any new questions or concerns prior to next appointment.

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
Wound Care:
Wound 1: LLL lateral distal.
Wound Debridement
Wound Condition: *Stable Chronic*
Wound Size: *Length= 0.2cm x Width= 0.1cm x Depth= 0.1cm*
Anesthetic: *Topical lidocaine 2%*
Type of Debridment: *non selective, Mechanical*
Cutting Instrument: *guaze*
Deepest Layer of Tissue Removed: *dermis*
Description of Tissue Removed: *slough, exudate, viable, non viable, devitalized*
Viable Bleeding Tissue Encountered: *Yes*
Pain Control: *Good, Patient reports no significant pain*
Subsequent Wound Debridment: *Yes*

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Wound Size Post Procedure: *Length= 0.2cm x Width= 0.2cm x Depth= 0.1cm*

Dressing: *Today applied patient bacitracin. Pt to apply bacitracin/zinic ontiment as primary dressing, covered with a 4x4 gauze wrapped in kerlix secured with metafix tape.*

Compression: *Pt to wear his own compression*

Return Visit: *One week*

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, debridement was carried up to and including, the deepest layer indicated above., The wound was 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):, none removed, Bleeding was controlled by the following method(s):, direct pressure.

Procedure Codes

97602 wound(s) care non-selective facfee
97602 wound(s) care non-selective prof fee

Follow Up

3-4 Weeks (Reason: followup, eval and management of chronic ulcer left leg)

Images

GRAHAM, Lawrence **DOB:** 02/05/1957 (66 yo M) **Acc No.** 91165 **DOS:** 12/12/2023

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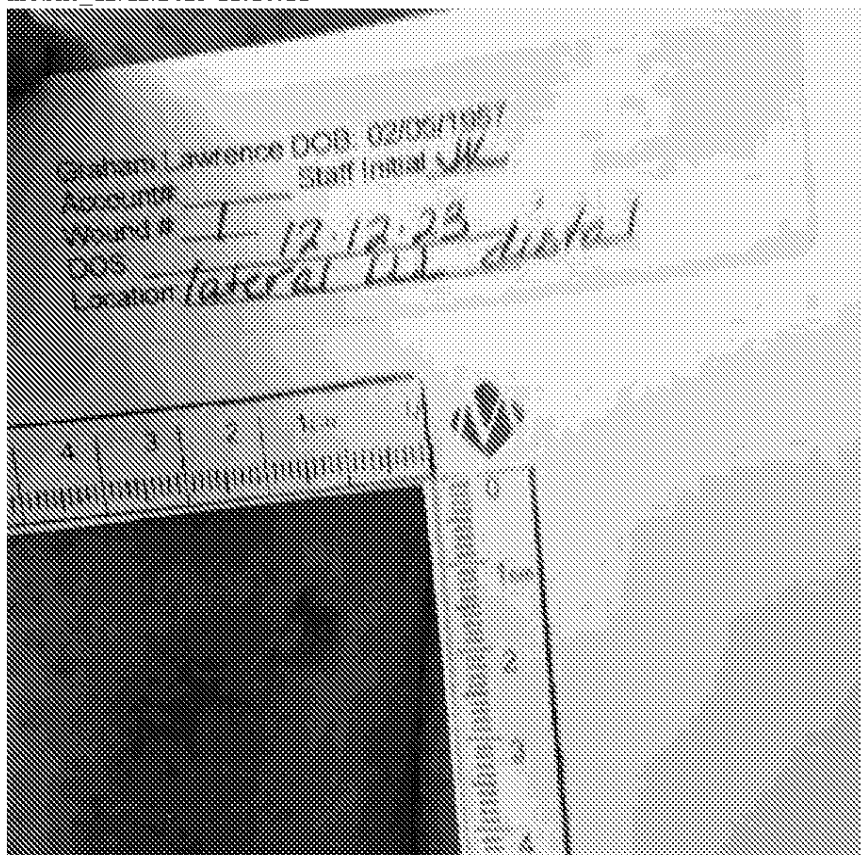

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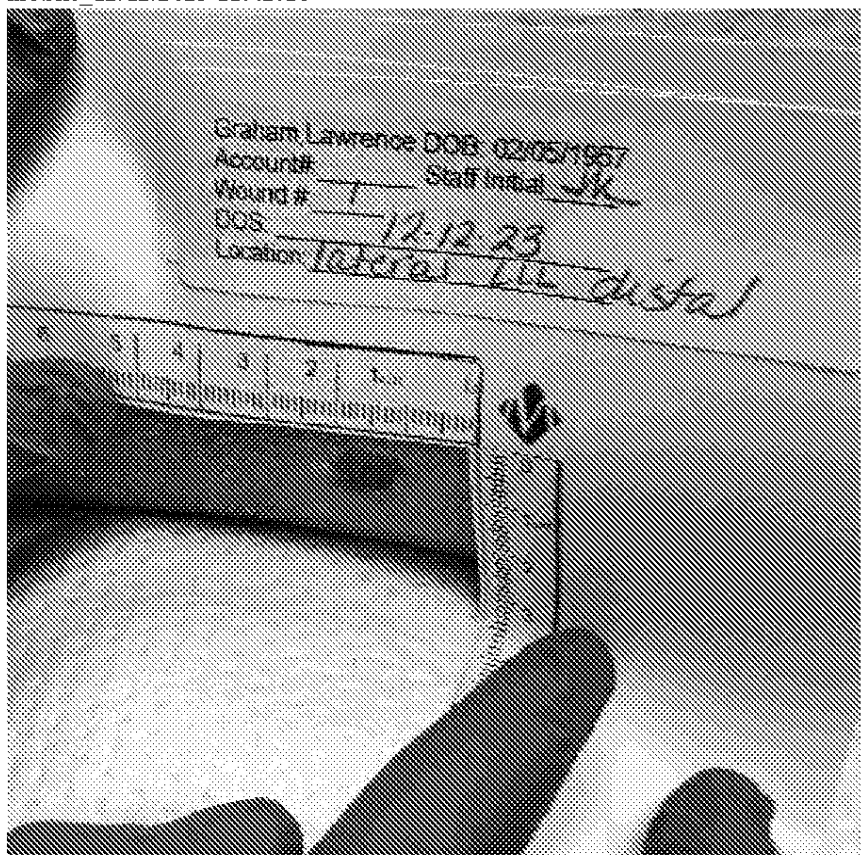

Electronically signed by Elizabeth Foster on 12/12/2023 at 01:12 PM EST

Sign off status: Completed

MHM Wound and Hyperbaric
1293 E Parkdale Ave

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Progress Note: Elizabeth Foster 12/12/2023

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