MonroeSurgical Hospital

PATIENT NAME_____(_____)__
LAST FIRST M.I. *Preferred name*

MAILING ADDRESS_____
STREET CITY STATE ZIP

PHYSICAL ADDRESS_____
STREET CITY STATE ZIP

_____-_____-_____ _____/_____/_____ (____)_____-_____ (____)_____-_____
SOCIAL SECURITY # DATE OF BIRTH HOME PHONE CELL PHONE

EMPLOYER_____ (____)_____-_____
WORK PHONE

MARITAL STATUS: □ MARRIED □ SINGLE □ DIVORCED □ WIDOWED

PRIMARY INSURANCE

INSURED'S NAME_____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT_____

ADDRESS_____
STREET CITY STATE ZIP

_____-_____-_____ ____/____/____ (____)____-_____ (____)____-_____
SOCIAL SECURITY # DATE OF BIRTH HOME PHONE CELL PHONE

EMPLOYER_____ (____)____-_____
WORK PHONE

POLICY #_____ GROUP #_____

SECONDARY INSURANCE

INSURED'S NAME_____
LAST FIRST M.I.

RELATIONSHIP TO PATIENT_____

INSURANCE CARRIER_____ EFFECTIVE DATE_____
POLICY #_____ GROUP #_____

COMMUNICATION REGARDING MY ACCOUNT

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communication,

_____ _____
Patient or responsible party's signature Date

If not patient, relationship to patient_____

PATIENT MEDICAL HISTORY

Patient Name_____ **Date of Birth**_____

PREFERRED LANGUAGE: _____ □ MALE □ FEMALE

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

□ It is alright to leave a message on my phone
□ It is alright to leave a message on my cell phone
□ It is alright to call me on my work phone

NAME OF PERSON COMPLETTING FORM: _____
RELATIONSHIP TO PATIENT: □ SELF □ PARENT □ SPOUSE □ CHILD □ OTHER
CONTACT IN CASE OF EMERGENCY: _____
RELATIONSHIP TO PATIENT: □ FRIEND □ PARENT □ SPOUSE □ CHILD □ OTHER
PHONE NUMBER OF CONTACT PERSON: HOME: _____ CELL: _____ WORK: _____
WHAT PROCEDURE ARE YOU SCHEDULED FOR? _____ DATE: _____

HEIGHT: _____ WEIGHT: _____

ENVIRONMENTAL ALLERGIES

Name of Substance (check all that apply)	Type of reaction
□ Iodine □ X-ray dye □ Latex Allergy □ balloons □ Urinary catheter	
□ Avocados □ Bananas □ Kiwi □ Chestnuts □ Shellfish □ Other food allergy _____	
□ tape □ staples □ detergent □ mold/mildew □ animal dander □ chemicals □ other Environmental Allergies _____	

Allergy	Reaction	Allergy	Reaction

CHIEF COMPLAINT: _____

MODE OF ARRIVAL: □ WALKED □ WHEELCHAIR □ STRETCHER □ CARRIED

DO YOU HAVE AN ADVANCED DIRECTIVE? □ YES □ NO
****BRING COPY OF ADVANCED DIRECTIVES TO GO IN YOUR MEDICAL RECORD**
ARE YOU AN ORGAN DONOR? □ YES □ NO
MEDICATIONS TAKEN IN LAST SIX MONTHS. CHECK ALL THAT APPLY:
□ ANESTHESIA □ CORTISONE □ BLOOD THINNER □ TRANQUILIZERS □ PAIN PILLS □ HEART MEDICATIONS
□ CHEMOTHERAPY □ RADIATION THERAPY
HEALTH ACCESSORIES: □ UPPER DENTURES □ LOWER DENTURES □ PARTIAL DENTURES □ GLASSES □ HEARING AID
□ ARTIFICIAL EYE □ RIGHT □ LEFT
CURRENT PHARMACIES USED: _____

I AM UNDER THE CARE OF THESE PHYSICIANS: _____

FAMILY HISTORY: (PARENT, SIBLING, GRANDPARENT)
□ HEART DISEASE □ CANCER □ HYPERTENSION □ ASTHMA □ COPD □ DIABETES □ SEIZURES □ SUICIDE
□ ANY FAMILY OR PERSONAL HISTORY OF MALIGNANT HYPERTHERMIA □ OTHER: _____

***PLEASE CIRCLE ALL THAT APPLY TO YOU (NOW OR IN THE PAST):**

EYES, EARS, NOSE AND THROAT
*VISUAL PROBLEMS
*LOOSE TEETH
*DENTURES/PARTIALS
*POOR FITTING DENTURES
*FREQUENT SINUS INFECTIONS
*FREQUENT EAR INFECTIONS
*FREQUENT TONSILLITIS
*HEARING PROBLEMS
OTHER: _____
NONE

CARDIOVASCULAR
*BLOOD CLOTS/DEEP VEIN THROMBSIS (DVT)
*HEART ATTACK DATE: _____
*PERIPHERAL VASCULAR DISEASE (POOR CIRCULATION)
*VALVE DISEASE
*PULMONARY EDEMA
*HEART FAILURE; RIGHT SIDE HEART FAILURE (CHF)
*BLOOD PRESSURE ISSUES: H=HIGH L=LOW
*IRREGULAR HEART BEATS
*DEFIBRILLATOR/PACEMAKER
*STENT/CATH_____
OTHER: _____
NONE

RESPIRATORY
*EMPHYSEMA
*ASTHMA
*RECENT UPPER RESPIRATORY INFECTION
*TUBERCULOSIS
*PULMONARY EMBOLISM (blood clot to lung)
*SLEEP APNEA
*SHORTNESS OF BREATH
*PNEUMONIA
*PRODUCTIVE COUGH
*HOME OXYGEN _____ LITER FLOW
OTHER _____
NONE

GASTROINTESTINAL
* BRIGHT RED BLOOD IN BOWEL MOVEMENT (GI BLEED)
*REFLUX
*GASTRIC ULCER
*COLITIS
*IRRITABLE BOWEL SYNDROME
*DIVERTICULITIS/DIVERTICULOSIS
*BOWEL OBSTRUCTION
*COLOSTOMY
*ILEOSTOMY
OTHER: _____
NONE

GENITOURINARY
*KIDNEY STONES
*FREQUENT URINARY TRACT INFETIONS
*DIALYSIS
*PROSTATE PROBLEMS
*POST MENOPAUSAL
*HEAVY BLEEDING OTHER THAN MENSES
*OSTOMY
LMP: _____ GYN _____
OTHER
NONE

NEUROLOGICAL
*DEPRESSION *ANXIETY
*DEMENTIA *WEAKNESS
*TREMORS *TINGLING
*NUMBNESS *STROKE
*TIA *VERTIGO/DIZZINESS
*SEIZURES *HEAD INJURY
*ALTERED MENTAL STATUS
OTHER: _____
NONE

MUSCULOSKELETAL
*TOTAL JOINT REPLACEMENT
*AMPUTEE
*PROTHESIS
*PARALYSIS
*ARTHRITIS
*FIBROMYALGIA
OTHER: _____
NONE

ENDOCRINOLGY
*CONTROLLED DIABETES
*UNCONTROLLED DIABETES
*HEPATITIS
*PANCREATITIS
*HYPOGLYCENIA
*THYROID PROBLEMS
OTHER: _____
NONE

PREVIOUS SURGERIES
*CABG
*APPENDECTOMY
*HERNIA REPAIR
*CHOLECYSTECTOMY
*TUBAL LIGATION
*HYSTERECTOMY
*CARPAL TUNNEL RELEASE
*PROSTATE SURGERY
*CATARACT
OTHER: _____
NONE

SKIN INTEGRITY
*CHRONIC SKIN CONDITION *EDEMA
*SKIN HEALING PROBLEMS *RASH
*WOUNDS/ULCERATIONS *INFUSAPORT
*DIALYSIS ACCESS *TATTOOS
*SKIN CANCER
OTHER: _____
NONE

HEMATOLOGY/ONCOLOGY
*BLEEDING DISORDERS *ANEMIA
*TRANSFUSION REACTION *HIV/AIDS
*PREVIOUS BLOOD TRANSFUSION DATE: _____
*HISTORY OF ANTIBODY
*RADIATION DATE OF LAST TREATMENT: _____
*CHEMOTHERAPY DATE OF LAST TREATMENT: _____
*CANCER (TYPE) _____
OTHER: _____
NONE

OTHER HEALTH INFORMATION
Have you ever been told that you have had MRSA infection? □Yes □No Date_____
Have you ever been told that you had a VRE infection? □Yes □No Date_____
Do you use tobacco products? □No □Yes □Chews□Dips □Smokes
Number of years smoked: _____ Number of packs/day: _____ Year quit smoking: _____
Do you drink alcohol? □No □Yes Type: _____ Amount: _____ Frequency: _____
Do you use recreational drugs? □No □Yes Type: _____ Amount: _____ Frequency: _____

Vaccinations
Have you had a flu shot within the last 12 months? □Yes □No
Have you had a pneumonia shot within last 5 years? □Yes □No
Tuberculin skin test date: _____ □Positive □Negative
□Hepatitis B vaccine (series of 3) Shingles vaccine within the last 4 weeks □Yes □No
□HPV vaccine □Childhood vaccinations up to date □Unknown vaccination history

PSYCHOSOCIAL ASSESSMENT

MARITAL STATUS □ MARRIED □ SINGLE □ WIDOWED

OCCUPATION: _____□ FULL TIME □ PART TIME □ RETIRED □ MORE THAN ONE JOB □ UNEMPLOYED

LEVEL OF EDUCATION: _____

DO YOU LIVE ALONE? □ YES □ NO WITH WHOM DO YOU LIVE? _____

DO YOU HAVE HOME HEALTH ASSISTANCE AT HOME? □ YES □ NO NAME OF AGENCY: _____

DO YOU LIVE IN AN ASSISTED LIVING CENTER? □ YES □ NO NAME OF CENTER: _____

DO YOU HAVE HOSPICE? □ YES □ NO NAME: _____

DO YOU LIVE IN A NURSING HOME? □ YES □ NO NAME: _____

DO YOU HAVE A COMPANY THAT PROVIDES MEDICAL EQUIPMENT TO YOU AT HOME? □ YES □ NO

NAME: _____

CHECK ALL EQUIPMENT THAT YOU HAVE AT HOME: □ WHEELCHAIR □ WALKER □ HOSPITAL BED □ CPAP □ BIPAP □ NEBULIZER □ BEDSIDE COMMODE □ SHOWER SEAT □ HOME OXYGEN

CONCERNS WITH HOSPITALIZATON: □ CHILD CARE □ JOB □ RELIGIOUS PRACTICES – RELIGION: _____

□ CULTURAL PRACTICES – SPECIFIC: _____ □ FINANCES □ PRIMARY CAREGIVER TO DEPENDENT PERSON

□ ANTICIPATE NEEDING HELP AFTER DISCHARGE □ CONFLICT ISSUES THAT COULD AFFECT VISITATION

PAIN ASSESSMENT

DO YOU HAVE PAIN? □ YES □ NO PAIN SCALE (0-10): _____

LOCATION: □ GENERALIZED □ FRACTURE □ SURGICAL SITE □ WOUND □ HEADACHE □ CHEST PAIN □ ABDOMINAL PAIN □ BACK PAIN □ PLEURAL PAIN □ FLANK PAIN □ MUSCLE CRAMPS

PATTERN: □ ACUTE □ CHRONIC □ CONSTANT □ INTERMITTENT □ INTERNAL □ EXTERNAL □ OCCURS DAILY

CHARACTER: □ ACHING □ PRESSURE □ RADIATING □ BURNING □ STINGING □ MISERABLE □ SHARP □ STABBING □ TINGLING □ DULL □ CRAMPING □ THROBBING

WHAT MAKES YOUR PAIN WORSE? □ COUGHING/DEEP BREATHING □ ANXIETY/FEAR □ TREATMENT/PROCEDURE □ MOVEMENT/POSITIONING □ NOTHING

WHAT MAKES YOUR PAIN BETTER? □ EATING □ MASSAGE □ REPOSITIONING □ TOILETING □ VERBAL SUPPORT □ RELAXATION TECHNIQUES □ PAIN MEDICATION □ NOTHING

TB ASSESSMENT

CHECK SYMPTOMS IF THEY ARE PRESENT: □ NEW ONSET OF COUGH FOR LONGER THAN 2 WEEKS □ NIGHT SWEATS □ FATIGUE □ CHEST TIGHTNESS □ I HAVE NONE OF THE ABOVE SYMPTOMS

MISCELLANEOUS ASSESSMENTS

□ WEIGHT CHANGES OF MORE THAN 10 POUNDS WITHIN THE LAST MONTH

□ CHANGES IN APPETITE/EATING HABITS LONGER THAN 3 DAYS

□ NAUSEA/VOMITING/DIARRHEA LONGER THAN 3 DAYS □ PRESSURE ULCER

□ PEG TUBE/TUBE FEEDING/HYPERALIMENTATION □ TOOTH OR MOUTH PROBLEMS THAT MAKE IT HARD TO EAT

□ EATS FEWER THAN 2 MEALS A DAY

HAVE YOU FALLEN IN THE LAST 6 MONTHS? □YES □NO

ARE YOU DIABETIC? □YES □NO

DO YOU HAVE PROBLEMS WITH YOUR FEET? □YES □NO WHICH FOOT? □LEFT □RIGHT □BOTH

CHECK ALL THAT APPLY: □ULCER □DISCOLORATION □NUMBNESS/TINGLING □CALLUS □BLISTER □SWELLING □ABNORMAL SHAPE OF FOOT □THICK TOENAILS □INGROWN TOENAILS

BECAUSE SO MAY PEOPLE DEAL WITH FEAR AND ABUSE, WE ASK ALL OUR PATIENTS: ARE YOU BEING HURT, HIT OR FRIGHTENED BY ANYONE AT HOME OR IN YOUR LIFE? □YES □NO

HAVE YOU EVER ATTEMPTED SUISIDE? □YES □NO

RN SIGNATURE: _____ DATE: _____ TIME: _____

Name:	Primary Doctor:
Pharmacy:	Pharmacy Phone #:

MEDICATION	DOSE	FREQUENCY	LAST DOSE TAKEN

Monroe Surgical Hospital

2408 Broadmoor Blvd. ▪ Monroe, LA 71201 ▪ 318-812-9502 ▪ Fax 318-410-1960

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA's privacy rules generally give you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. To better serve you, please complete the following:

PLEASE CONTACT ME IN THE FOLLOWING MANNER:

VERBAL COMMUNICATION:

Home / Cell / Work

Please Identify Your Preferred Phone Number: (___) - ____ - _____

- ☐ Leave message with detailed information.
- ☐ Leave message with call back number only.

WRITTEN COMMUNICATION:

- ☐ Mail to this address: _____
- ☐ Fax to this number: _____
- ☐ Email Address: _____

FAMILY MEMBER(S) OR FRIENDS(S) WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION AND RELEASE PHI TO:

Name: _____ Address:_____ Relationship: _____

Name: _____ Address: _____ Relationship: _____

Name: _____ Address: _____ Relationship: _____

Name: _____ Address: _____ Relationship: _____

I understand it is my responsibility to provide this office with written changes to the release of my PHI.

Patient's Printed Name: _____DOB:_____

Patient Signature: _____ Date: _____

Release to: _____

Tobacco-Free Agreement for Inpatients

As a supporter of health and wellness, and to protect our patients, visitors and staff, Monroe Surgical Hospital is a tobacco-free campus. This means all forms of tobacco are prohibited, including cigarettes, cigars, electronic smoking devices, hookahs, chew, snuff, and spit tobacco products.

No tobacco use is allowed anywhere on Monroe Surgical Hospital or Affinity Walk-In Clinic properties, including the building, grounds, parking areas, sidewalks, benches, and parked vehicles.

While Monroe Surgical Hospital encourages patients and staff to consider quitting the use of tobacco, this policy does not require anyone to quit, but it does require all persons (patients, family members, visitors, and staff) to refrain from the use of tobacco while present on our property.

The admitting physician, at his/her discretion, may order nicotine replacement products if deemed necessary.

For the safety of our patients and staff, Monroe Surgical Hospital employees are required to report to the physician:

- Patients observed using tobacco products
- Patients leaving the facility without being discharged
- Inappropriate behavior and/or verbal abuse

By signing this agreement, I acknowledge that:

- I understand Monroe Surgical Hospital is a tobacco-free facility;
- I will refrain from tobacco use while at this facility;
- I understand that my family members and my visitors must also refrain from tobacco usage;
- I understand my physician will be notified if I am observed using tobacco products, leaving the facility without discharge, or displaying inappropriate behaviors.

Patient Signature: _____

Date: _____

MonroeSurgical Hospital

2408 Broadmoor Blvd.
Monroe, LA 71201

PATIENT PORTAL & PROXY ACCESS

_____ NEW ENROLLEE _____ PROXY ACCESS

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

I have read and understand the Monroe Surgical Hospital Patient Portal Information document. I understand the risks and benefits of patient portal and agree that I understand the risks associated with online communications between the hospital and the patient. I consent to the conditions outlined in the Patient Portal Information document. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Monroe Surgical Hospital should I decide against using the patient portal.

_____ _____
Patient Signature **Date**

PROXY INFORMATION (Person to whom you authorize Monroe Surgical Hospital to release Patient Portal access)

Proxy Name: _____ Date of Birth: ____/_____/_____
LAST FIRST M.I.

Address: _____ Phone: _____
Street Address City State Zip Code

Email Address: _____ (Personal email address only, please)

Please Indicate the Proxy Access outlined below that describes the proxy access requested:

_____ Adult – Patient must sign this form to provide authorization for release of his/her medical information. Proxy Access valid until revoked by the patient.

_____ Legal Guardian of Adult Patient - Legal guardian by court order, Power of Attorney for Health Care, or other legal arrangement. A copy of the legal document must accompany this request form. You must notify Monroe Surgical in case of any change in authority.

_____ Minor Patient – Must have parental rights or legal guardianship rights. If a guardianship exists, this request must be accompanied by a copy of the court order appointing the guardian. Information regarding reproductive health, STDs, mental health, and/or substance abuse will only be made available to a parent or guardian with consent of the minor patient.

By signing below, I acknowledge and agree that:

- I will be using my own Patient Portal account to access the patient's portal account.
- I will comply with the conditions outlined in the Patient Portal Information document.
- The patient can revoke my access to his/her Patient Portal account at any time

_____ _____
Proxy Signature **Date**

_____ _____
Patient Signature (if applicable) **Date**

MonroeSurgical Hospital

THINGS TO REMEMBER

Notes: It is usually beneficial to bring familiar toys, blankets, movies, etc. to the hospital.

1. Nothing to eat or drink after midnight on the night prior to your procedure unless otherwise instructed.
2. Take your heart and blood pressure medications with a sip of water on the morning of your procedure unless otherwise instructed.
3. Hold medications that may interfere with your specific procedure. Examples: blood thinners, aspirin, antihistamines, MOA inhibitors, antidepressants, tranquilizers sedatives, insulin and other diabetic medications (some of these meds are held for certain procedures). Ask physician or nurse for instructions.
4. Complete bowel prep specific to your procedure if applicable. Ask physician or nurse for instructions.
5. If your physician provides a prescription for pain medication prior to your procedure, please have your pharmacist fill the prescription so it will be available when you go home. Keep your post-op pain in a manageable state during your hospital visit and home recovery. Use your medication wisely and follow instructions provided by your pharmacist.
6. Plan to maintain an appropriate activity level as described by your physician and discharge nurse.
7. Wear cotton underwear and socks. (You can possibly leave them on during your procedure).
8. You will need someone to drive you home.
9. Advise your family that we have no cafeteria on the premises. Catered nourishment is provided for the patients.
10. The front lobby doors lock at 6pm. Entrance into the facility is available through the double doors located near the observation unit nurses station until 9pm. Thereafter entrance is obtained by pressing the button outside the observation unit doors. There are no set visiting hours.

Your procedure is scheduled for _____ (date) _____ (Tentative time).

(Please be aware that the surgery schedule changes, therefore your arrival time may change. We will attempt to notify you of changes).

BE AT MONROE SURGICAL HOSPITAL ON: DATE: _____AT :_____(Tentative Time)

If date and time unknown, please call Monroe Surgical Hospital for instructions. 318-410-0002 (main number) or 318-812-9546 pre-admissions number.

***PLEASE BRING YOUR HOME MEDICATIONS *IN THE ORIGINAL PRESCRIPTION BOTTLE* the day of your procedure. Our Pharmacist will identify your mediations. Your physician can review them and write orders for their usage. This will allow the RN to administer your own medications as prescribed without further costs to you and/or your insurance company.**

MONROE SURGICAL HOSPITAL
PATIENT PORTAL

Thank you for choosing Monroe Surgical Hospital as your provider of medical services. Our Goal is to provide you with excellent care and hospitality. In compliance with the federal government's Meaningful Use Initiative, all hospitals will soon be required to provide patients (and/or a patient-authorized user) access to their patient record electronically. Having this electronic access through your personal, secured email will allow you as the patient the ability to review your medical record during your stay here at our facility. This access provides you with information, including but not limited to, medical procedures completed, medical history, medications taken, allergies, existing or developing medical conditions, etc. You can also download your confidential medical record to your own private computer for your personal records, as well as electronically share your record with another medical professional of your choice if there is a need.

Upon your discharge from our hospital, the email address you shared with us during the registration process will receive an auto-generated email from our electronic health record. This email will direct you to step-by-step instructions on how to access your personal medical record.
If you have any questions or concerns regarding this new initiative you can call us at **318-410-0002** and/or contact the Centers for Medicare and Medicaid Services website: http://cms.gov, and search "Meaningful Use."

Thanks again for choosing Monroe Surgical Hospital
& we hope you have a pleasant stay with us.

Patient Portal Access
Frequently Asked Questions

What is the Patient Portal?

The Monroe Surgical Hospital Patient Portal is an online health electronic document management tool that includes a view of clinical data from your Electronic Medical Record (EMR).

The clinical data on the Patient Portal includes:

- Test results
- Medications
- Allergies
- Immunizations
- Health Issues

How do I access the Patient Portal once I have completed the invitation/account set-up process?

For future visits to the Monroe Surgical Hospital Patient Portal **after** you have completed the initial setup process, you can log in at: https://www.mymedicalencounters.com. Remember, use this link after you have received a portal invite and completed the sign-up process.

Do I need special equipment?

No. All you need is access to a computer, an internet connection, and access to the email account that you provided during hospital registration.

How do I set up an account?

Step-by-step instructions on how to set up an account are included in this brochure. Once you have entered your information and have been prompted to create a username and password, you will only need your username and password to sign into your Patient Portal account in the future.

Can my family/friends access the information found on my Portal?

Yes, but only after you have given them permission. As a patient of Monroe Surgical Hospital, you can choose to give an authorized representative access to specific hospital visits. You will be asked this information during the admission process.

Who should I contact if I have trouble logging in or accessing the Patient Portal?

If you have trouble logging in or accessing Monroe Surgical Hospital's Patient Portal, contact Monroe Surgical Hospital's registration department at **318-410-0002** Monday through Friday from 8am - 4:30pm CST.

Will I receive emails after each admission to the hospital?

No. After each admission to the hospital a new summary of care document will post to your patient portal. You may access the document any time after you are discharged. Once the initial email has been sent, the patient or authorized representative will not be sent new emails with each new visit.

What if I have questions about my medical records?

If you have questions about your medical records, or feel that an error has been made, please contact Monroe Surgical Hospital's Medical Records Department at **318-812-9507**.

Accessing your account

To access your account or additional accounts at a later time, please visit:
https://www.mymedicalencounters.com/.

The Monroe Surgical Hospital Patient Portal relates to services provided at <u>Monroe Surgical Hospital ONLY</u> and will not include health information from any other health care facilities that you may have utilized for health services.

<u>How to Register for Monroe Surgical Hospital's Patient Portal:</u>
<u>A Step-by-Step Process</u>

Step 1
You will receive an email invitation to create your patient portal account. Click on the link provided in the email to start the registration process.

Step 2
Enter first name, last name and date of birth. The Profile # and email will pull from the link provided in the email. Next create a user ID and password. Select the checkbox verifying the information is correct and then hit REGISTER.

Step 3
Select three security questions and provide answers. These are needed in case your password is forgotten.

Step 4
Select on the Main Menu button.

Step 5
View Clinical Information.

Step 6
Select the applicable patient account to view (if you are an authorized representative for more than one account, you will see all of them listed here).

Step 7
Select applicable account. All accounts for your visits to Monroe Surgical Hospital will be listed here.

Step 8
Your patient summary information will now show. This will include information from your admission to the hospital such as test results, medications, allergies, immunizations and health issues.

Step 9
To view another account, select "Clinical Information."