You are scheduled for (EGD/Colonoscopy/Hemorrhoid Treatment) at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Center on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please arrive at admitting at the hospital at \_\_\_\_\_\_\_\_\_\_. Please plan to be at the hospital for several hours depending on your procedure. It is necessary for someone to stay with you during your procedure, take responsibility for your valuables and drive you home.

**On \_\_\_\_\_\_\_\_\_\_\_\_\_, the day before your procedure, you can ONLY HAVE CLEAR LIQUIDS. NO solid foods or milk products.**

List of acceptable clear liquids:

* Apple Juice
* Soda (Sprite, 7-up, Coca Cola, etc.)
* Tea

\*\*\*\*\*DO NOT FOLLOW THE INSTRUCTIONS ON THE SUTAB BOX! Follow only these instructions\*\*\*\*\*

* Coffee (NO milk or creamer. Sugar/sweeteners are okay)
* Broth – from bouillon or cubes only
* Gatorade (NO red or purple)
* Jello (NO red or purple)
* Popsicles (NO fruit or pulp. NO red or purple)

Do not eat any salads, nuts, seeds, corn, or peas, popcorn, mushrooms, tomoatoes, or peppers one week prior to test.

**\*\*\*DO NOT TAKE aspirin 10 days prior. If taking any other blood thinners, contact physician for instructions\*\*\***

**\*\*\*\*\*DO NOT TAKE any medications the morning of your procedure\*\*\*\*\***

**Start drinking your prep at 6:00 PM the day before your procedure**

**Step 1:** Open 1 bottle of 12 tablets.

**Step 2:** Fill the provided container with 16 ounces of water (up to the fill line). Swallow each tablet with a sip of water, and drink the entire amount of water over 15 to 20 minutes.

**Step 3:** Approximately 30 minutes after your last pill, fill the provided container with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

**Step 4:** Your second dose will be at \_\_\_\_\_\_\_\_\_\_ (time) on \_\_\_\_\_\_\_\_\_\_\_ (date). Repeat step 2 and 3.

**\*\*You CANNOT have anything else to eat/drink after step 4 above.**

\*\*If you need to cancel or reschedule, please give a 7 day notice. Rescheduling may delay your diagnosis and treatment for several weeks.

\*\*A representative from our office (and the facility) will call you prior to your procedure to collect your estimated copay, deductible or coinsurance. Estimated out of pocket expenses must be paid up front.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SuTab