

Your procedure will be performed by Doctor: _____

Address: _____

Date of procedure: _____ Arrive at: _____ AM/PM

Comments: _____

SUPREP[®] BOWEL PREP KIT

(sodium sulfate, potassium sulfate and magnesium sulfate)
Oral Solution

(17.5g/3.13g/1.6g) per 6 ounces



On the day *before* your procedure...

What You **CAN** do:

- You may have a light breakfast or have clear liquids **ONLY**; please have nothing for dinner

What You **CANNOT** do:

- **DO NOT** drink milk
- **DO NOT** eat or drink anything colored red or purple
- **DO NOT** drink alcoholic beverages

Any of the following liquids are **OK** to drink:

- Water
- Strained fruit juices (without pulp) including apple, orange, white grape, or white cranberry
- Limeade or lemonade
- Coffee or tea (**DO NOT** use any dairy or non-dairy creamer)
- Chicken broth
- Gelatin desserts without added fruit or topping (**NO RED OR PURPLE**)

Note:

- SUPREP Bowel Prep Kit is indicated for cleansing of the colon as a preparation for colonoscopy in adults
- Be sure to tell your doctor about all the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. SUPREP Bowel Prep Kit may affect how other medicines work
- Medication taken by mouth may not be absorbed properly when taken within 1 hour before the start of each dose of SUPREP Bowel Prep Kit
- The most common adverse reactions after administration of SUPREP Bowel Prep Kit were overall discomfort, abdominal distention, abdominal pain, nausea, vomiting, and headache
- If you have any questions about taking SUPREP Bowel Prep Kit, call your doctor

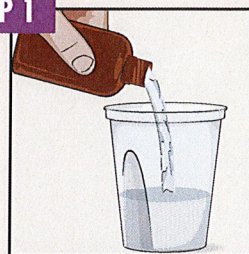
To learn more about this product, please call **1-800-874-6756** or visit our Web site at **www.suprekit.com**

SUPREP Bowel Prep Kit is a split-dose (2-day) regimen. Both 6-ounce bottles are required for a complete prep.

FIRST DOSE: Begin Step 1 at _____ PM the evening before your procedure and proceed as shown below:

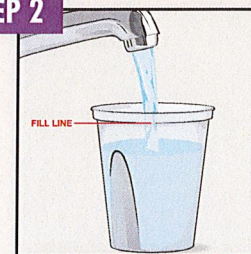
You must complete Steps 1 through 4 using one (1) 6-ounce bottle before going to bed:

STEP 1



Pour **ONE (1)** 6-ounce bottle of SUPREP liquid into the mixing container.

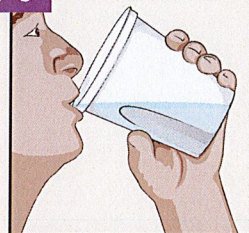
STEP 2



Add cool drinking water to the 16-ounce line on the container and mix.

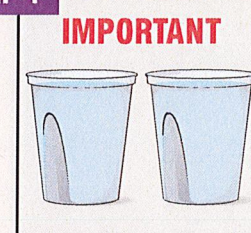
NOTE: Dilute the solution concentrate as directed prior to use.

STEP 3



Drink **ALL** the liquid in the container.

STEP 4



You **must** drink two (2) more 16-ounce containers of water over the next 1 hour.

SECOND DOSE: Begin Step 1 at _____ AM the morning of your procedure and proceed as shown above:

For this dose, repeat Steps 1 through 4 shown above using the other 6-ounce bottle.

NOTE: You **must** finish drinking the final glass of water at least 2 hours, or as directed, before your colonoscopy.



Medical Clinic of Houston, L.L.P.

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Policy for late cancellations and “no-show” patients for Gastroenterology procedures

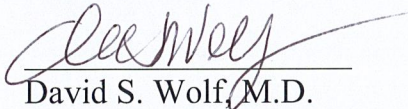
When we schedule your gastroenterology procedure, we are reserving the physician’s time, staff time, anesthesiologist’s time, and a procedure room for you and your particular medical needs. If you cancel at the last minute or do not appear for your scheduled procedure, we generally cannot use this time to provide care for another patient.

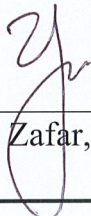
Effective November 15, 2022, we will charge a \$100 fee if you cancel your procedure with notice of less than three business days (72 hours) or if you do not appear for your procedure. We will ask that this fee be paid prior to scheduling any future appointments or procedures with a MCH gastroenterologist. This fee will not be covered by your insurance and will be due from you directly.

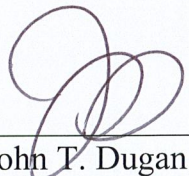
It is not our intent to be punitive but, instead, to ensure that (a) you are not compromising your care, and (b) we are able to care for all of the patients who need our care. If we know in advance that there is an opening, we can fill that appointment slot with another patient who has a medical need.

We appreciate your understanding.

Thank you,


David S. Wolf, M.D.


M. Behzad Zafar, M.D.


John T. Dugan, M.D.

By signing below, you acknowledge that you have received and understand this policy

Patient signature

Date

Printed name

For office use only:

Attestation that this information was relayed orally to the patient and that the patient expressed understanding.

Patient name and DOB

MCH account #

Staff member signature

Date

Witness name/signature

Date