

Bowel Preparation Instructions

Items necessary to purchase:

- **SUPREP Bowel prep kit** –Prescription required and has be e-scribed to your local pharmacy
- **Disregard** instructions on prep kit. Follow instructions below

5 days prior to your procedure, please avoid seeds and nuts as much as possible.

The day before your procedure:

- **NO SOLID FOODS ALL DAY LONG.** Consume only a clear/transparent liquid diet.
 - Water, Soda, Gatorade, black coffee, tea, popsicles, Jell-O, Broth/bouillon, apple juice, white grape juice, white cranberry juice.
- **AVOID RED AND PURPLE LIQUIDS**
- Drink plenty of clear liquids throughout the day to stay hydrated.
- **NOTHING AFTER MIDNIGHT EXCEPT FOR THE PREP AS DIRECTED**
- **NO ALCOHOL**

Prep Times for procedure:

Procedure time **7:00am to 10:30am**

Start Part A at 2 PM the afternoon before your procedure, finish by 4 PM

1. Take the mixing container provided and pour in one 6 oz. bottle of SUPREP and add 10 oz. of cold water to the fill line
2. Drink all the liquid in the container within 20 minutes.
3. Wait 20 minutes, drink 2 full containers of water (32 oz. total)

You can continue to drink clear liquids

Start Part B at 10 PM the night before your procedure, finish by Midnight

1. Take the mixing container provided and pour in one 6 oz. bottle of SUPREP and add 10 oz. of cold water to the fill line
2. Drink all the liquid in the container within 20 minutes.
3. Wait 20 minutes, drink 2 full containers of water (32 oz. total)

AFTER FINISHING PART B: DO NOT EAT OR DRINK ANYTHING ELSE

Procedure time **11:00am to 2:00pm**

Start Part A at 5 PM the evening before your procedure, finish by 7 PM

1. Take the mixing container provided and pour in one 6 oz. bottle of SUPREP and add 10 oz. of cold water to the fill line
2. Drink all the liquid in the container within 20 minutes.
3. Wait 20 minutes, drink 2 full containers of water (32 oz. total)

You can continue to drink clear liquids

Start Part B at 5 AM the morning of your procedure, finish by 7 AM

1. Take the mixing container provided and pour in one 6 oz. bottle of SUPREP and add 10 oz. of cold water to the fill line
2. Drink all the liquid in the container within 20 minutes.
3. Wait 20 minutes, drink 2 full containers of water (32 oz. total)

AFTER FINISHING PART B: DO NOT EAT OR DRINK ANYTHING ELSE

For a sore bottom try ointments such as A&D, Preparation H, or Vaseline to area as needed

Special Instructions

Please contact the office at 314-529-4900 option 4 if you have any items below:

- An implanted defibrillator and/or pacemaker
- You have had a cardiac stent placed in the last 12 months
- You are taking an antiplatelet medication with aspirin
- You are currently taking blood thinners such as Coumadin, Jantoven (warfarin), Pradaxa (dabigatran), Xeralto (rivaroxaban), Eliquis (apixaban), Clopidogrel (Plavix), Prasugrel (Effient), Ticagrelor (Brilinta)
- You are currently taking any diabetic or weight loss medication such as; Farziga, Jardiance, Mounjaro, Ozempic, Rybelsus, Trulicity, Victoza, Wegovy or Zepbound

Insulin: Please contact your prescribing physician and inform him/her that you cannot eat or drink after midnight before your procedure, then ask for instructions on how to adjust your insulin dosages

Herbal Medication: It is best to stop any herbal remedies 5 days before the procedure as many of them can thin the blood and increase risk of bleeding during or after the procedure.

SOMEONE WILL NEED TO DRIVE YOU TO AND FROM THE ENDOSCOPY CENTER THE DAY OF YOUR PROCEDURE

- Driver needs to stay at the facility during your procedure. Plan on staying for around 2 hours.
- You will not be able to drive or drink alcohol for 24 hours following your procedure.

Medication Reconciliation Form

Allergies (Examples: food, medications, latex, etc)

Medication Name	Reaction	Medication Name	Reaction

- List **ALL YOUR MEDICATIONS** including, eye drops, over-the-counter and alternative medicines such as vitamins, herbals, supplements and THC (cannabis).
- It is extremely important for your care and safety, that you provide complete and accurate information

Medication List

Medication Name	Dose	How often do you take it?	Why are you taking this medication?	Date of last dose taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				

It is suggested that you provide a copy of this list to your Primary Care Provider.

OFFICE USE ONLY

Reviewed By RN _____
Signature Date/ Time

- No Changes to Medications; Resume home medications
- Changes

New Medication Name	Dose	Frequency	Purpose of Medication

- Patient education regarding medication changes

Medications Reconciled by RN _____
Signature Date/ Time

Gateway Endoscopy Center and its providers are not responsible for medications ordered by other organizations or providers.
