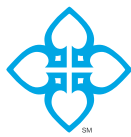


Lake Charles
Memorial Health System

PATIENT INFORMATION (PLEASE PRINT)

Last Name (Jr. Sr. etc.)	First Name	Middle Initial	Social Sec #

Date of Birth	Home Phone No.	Work Phone No.	Cell Phone No.

Address	City	State	Zip	Sex ☐ M ☐ F

	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Employer

Referring Physician	Primary Care Physician

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account (if different)	Home Phone No.	Work Phone No.	Cell Phone No.

Address	City	State	Zip	Sex ☐ M ☐ F

Date of Birth	Social Sec #	Employer	Email

PRIMARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy Holder Name	Employer Employment Status

Effective Date of Coverage	Policy Holders Address (if different from patient)

Group No.	Home Phone No.	Policy Holder's DOB	Policy Holder SS#

Policy No.	Cell Phone No.	Relationship to Patient

SECONDARY INSURANCE (CARD MUST BE PRESENTED TO RECEPTIONIST)

Insurance Co.	Policy Holder Name	Employer Employment Status

Effective Date of Coverage	Policy Holders Address (if different from patient)

Group No.	Home Phone No.	Policy Holder's DOB	Policy Holder SS#

Policy No.	Cell Phone No.	Relationship to Patient

EMERGENCY CONTACT INFORMATION

Name	Home Phone No.	Relationship to Patient
Name (not living in same household)	Home Phone No.	Relationship to Patient

~~WORKER'S COMP INFORMATION (IF APPLICABLE)~~

Worker's Compensation Co.	Date of Injury	Verification Call #

ADDITIONAL INFORMATION

Language	Ethnicity	Race
☐ English ☐ Spanish ☐ Other:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other:

I understand that I am responsible for supplying Memorial Medical Group, Inc. with my current insurance coverage, including presenting my insurance cards, and to inform Memorial Medical Group, Inc. of any changes to my insurance coverage. Failure to comply with the above will change my status to a self-pay account. I understand I will receive services performed through the Lake Charles Memorial Health System. In the event of any overpayment or credit to any of my accounts for any hospital, clinic, and/or physician services within the Lake Charles Memorial Health System, I do hereby authorize and consent to the transfer and application by the Lake Charles Memorial Health System of said overpayment or credit to any of my accounts with outstanding balances or sums due, if any, which accounts may be within the Lake Charles Memorial Health System. I understand that I am primarily responsible for the payment of this account, subject to the terms noted below:

PRIVATE INSURANCE – As a courtesy to me, Memorial Medical Group, Inc. may file my claims with my insurance carrier. I agree that my insurance benefits may be paid directly to Memorial Medical Group, Inc. If my insurance plan is in network with Memorial Medical Group, Inc., I agree to be responsible for the deductible, any patient portion as determined by my insurance plan, as well as, any services that are deemed not covered under my insurance policy. If my insurance plan is out of network, I agree to be responsible to Memorial Medical Group, Inc. for the full balance of Memorial Medical Group, Inc.'s charges that are not paid by my private insurance carrier, including any deductible and/or copayment.

MEDICARE – Memorial Medical Group, Inc. accepts Medicare assignment (Medicare approved charges). I understand that I am responsible for any deductible(s), coinsurance(s) or copayment(s). If there is a Medicare supplement insurance policy, Memorial Medical Group, Inc. will file my claims as a courtesy to me, and the benefits may be sent directly to Memorial Medical Group, Inc. If there is no supplemental policy, I am responsible for the payment of the balance of the assignment (Medicare 20% coinsurance).

MEDICAID – I understand that some providers in Memorial Medical Group, Inc. accept Medicaid and that I must present a current Medicaid card at each visit. If Medicaid discontinues or my visits are exhausted, I agree to be responsible for payment of the account.

WORKERS' COMPENSATION – I agree to allow Memorial Medical Group, Inc. to verify my Workers' Compensation coverage with my employer or my employer's insurance carrier. The employer or insurance carrier may request medical information in order to process claims. Any such information so requested will also be provided to the patient. I agree to be responsible for payment of all charges which are not paid by my employer or its Workers' Compensation insurance carrier.

NO INSURANCE – If there is no insurance or other such coverage for the charges of this account, I agree to pay the full balance of all charges in accordance with payment terms as agreed upon by Memorial Medical Group, Inc.

RELEASE OF INFORMATION – Should my insurance carrier, Medicaid, or Medicare request medical information and/or copies of my medical records in order to process my claim(s), Memorial Medical Group, Inc. has my permission to furnish same. Unless otherwise noted by me, I also give Memorial Medical Group, Inc. permission to furnish medical information and copies of my medical records to my referring and/or family physician.

If I fail to make any payment due as outlined above or as agreed upon, Memorial Medical Group, Inc. may turn this account over to a collection agency and/or attorney for handling. If this occurs, I may be subject to dismissal from Memorial Medical Group, Inc. If such action is taken on this account, I agree to pay the reasonable fees of said collection agency and/or attorney.

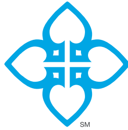
_______________________________________ _______________________________

Patient/Responsible Party (Signature) Date

CONSENT FOR TREATMENT - I, the undersigned, do hereby authorize Memorial Medical Group, Inc. to provide medical care as deemed necessary in the judgment of the provider. This treatment may include, but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and intravenous medications or other therapeutic solutions, and minor surgical procedures.

_______________________________________ _______________________________

Signature Date



HIPAA Consent

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, authorize Memorial Medical Group (MMG) to use and disclose my health information as required for treatment, payment, and healthcare operations as described in MMG's Notice of Privacy Practices. I hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Patient Name: ________________________________ (Please print.) Patient DOB:______________

Signature: ____ Date: ________________
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices and refused to accept.

Signature: ____ Date: ________________
Hereby acknowledge that I was given a copy of the Notice of Privacy Practices.

Relationship (if not signed by patient):____

METHOD OF COMMUNICATION

May we leave a message with any person answering your telephone if you are not available? ☐Yes ☐No
May we reach you by cellular phone? ☐Yes ☐No Cellular #____________________________
May we call your place of employment? ☐Yes ☐No Work #____________________________
May we confirm your appointment via text message? ☐Yes ☐No
May we confirm your appointment on your answering machine? ☐Yes ☐No
May we confirm your appointment with someone other than yourself? ☐Yes ☐No
If yes, please specify.

____

Name	Relationship to patient	Phone No. Including Area Code
Name	Relationship to patient	Phone No. Including Area Code

RELEASE OF PRESCRIPTIONS

****List individuals you designate to pick up your written prescriptions from this office on your behalf. The individual must present ID at time of pick up:**

Name	Relationship to patient	Phone No. Including Area Code
Name	Relationship to patient	Phone No. Including Area Code

____ _______________________________
Signature Date

FINANCIAL POLICY

In order for our medical staff to be able to deliver the quality of care that you expect, we have established this financial policy. In order for us to continue to provide high quality care and to ensure that your visit is as pleasant as possible, it was necessary to establish the following list of guidelines.

Please read all information and acknowledge by signing below:

1. We ask that you present your insurance card and a picture ID at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your deductible, co-payment, or charge from non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to turn your account over to a collection agency.
6. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your deductible is met.
7. **HMO-PPO PATIENTS:** If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-**NO EXCEPTIONS**. If you plan requires you to choose a primary care physician, it is ***your*** responsibility to make sure your insurance company has the Physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. Retroactive referrals are allowed for up to five days after services are rendered. If we do not participate with your plan, we will verify your out-of-network benefits, and will expect payment of your portion of the charges at the time of service.
8. **SELF-PAY PATIENTS:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements. You will be allowed to apply for financial assistance to see if you qualify for UCC or Medicaid.
9. No/show or missed appointments: When an appointment is scheduled with the doctor, time is specifically allocated for you. When an appointment is not canceled in advance and the patient "no-shows," another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel the appointment. If ***two*** appointments are missed without cancellation, you will be charged a fee of $25.00. If ***three*** appointments are missed, you may be considered for dismissal from the practice for non-compliance.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (337) 494-2776.

I have read and have a full understanding of the financial policy.

Printed Name	Signature	Date

GoLytely and NuLytely Bowel Prep Instructions

This product should be used the day before your colonoscopy.

PLEASE FOLLOW THE COLONOSCOPY DIET INSTRUCTIONS – YOU MUST BE ON A **CLEAR LIQUID DIET** FOR THE ENTIRE DAY BEFORE YOUR PROCEDURE.

THE NIGHT BEFORE YOUR COLONOSCOPY

- FIRST DOSE AT ___________. DRINK ½ GALLON IN 2 HOURS.
- SECOND DOSE AT ___________. DRINK ½ GALLON IN 2 HOURS.

IT IS IMPORTANT TO FOLLOW EACH STEP COMPLETELY.

Step 1: This product can be used with or without one of the flavor packets that comes with the bottle. If adding flavor, tear open flavor pack and pour contents into the bottle BEFORE reconstitution. Discard used flavor packs.

Step 2: Add lukewarm drinking water to the top line on bottle. Cap the bottle and shake to dissolve the powder. The mixed solution will be clear and colorless. Do not add anything else, such as additional flavorings, to the solution. When reconstituted, keep solution refrigerated. The reconstituted solution should be used within 48 hours.

Step 3: The first bowel movement usually occurs approximately 1 hour after you start drinking GoLytely and NuLytely. Continue to drink GoLythely/NuLytely until you have finished **ALL** of it. Your stool should be watery, clear and free of solid matter.

Step 4: Drink 1 (8oz) glass every 10 minutes. Rapid drinking of each portion is better than drinking small amounts continuously. The first bowel movement should begin approximately 1 hour after the start of GoLytely / NuLytely administration. You will have loose bowel movements for about 1-2 hours after you finish drinking the solution.

You should not drink any liquids less than 2 hours before your scheduled arrival time. For example, if your scheduled arrival time is 7am, you should complete drinking the prep and clear liquids by 5am.

Frank Marrero, MD, FACP | Khaled Nour, MD | Sarpreet Basra, MD | Eric Fontenot, MD
2770 3rd Ave, Suites 345A & 345B
Lake Charles, LA 70601
Phone: 337-494-4785 Fax: 337-494-4786

CLENPIQ®

(sodium picosulfate, magnesium oxide, and anhydrous citric acid) Oral Solution

10 mg/3.5 g/12 g per 160 mL bottle

WHAT IS CLENPIQ?

CLENPIQ is a prescription medicine that cleans your colon.
CLENPIQ is ready for you to drink right from the bottle. It does not need to be mixed or diluted.
Do not refrigerate or freeze CLENPIQ.

What's in the CLENPIQ box?

Two bottles of CLENPIQ (5.4 oz each)

An 8 oz cup for drinking clear liquids

The Patient Medication Guide and the Instructions for Use for your reference

Start Hydrating

On the day before your colonoscopy, start hydrating by consuming only clear liquids and stop eating all solid foods and dairy.

Make sure to hydrate before, during, and after the prep.
Follow your doctor's instructions completely.

ACCEPTABLE CLEAR LIQUIDS FOR HYDRATING	
Water	Ginger ale and other sodas
Black coffee or tea	Clear juices: such as apple or white grape juice
Clear broth or bouillon	Plain Jell-O
Sports drink	Frozen juice popsicle

LIQUIDS MUST NOT BE RED OR PURPLE. DO NOT CONSUME ANY ALCOHOL, JUICE PULP, MILK, CREAM, SOY OR NON-DAIRY CREAMER, OR OTHER LIQUIDS YOU CANNOT SEE THROUGH.

To learn more visit CLENPIQ.com

IMPORTANT SAFETY INFORMATION (CONTINUED)

- Your healthcare provider may do blood tests after you take CLENPIQ to check your blood for changes. Tell your healthcare provider right away if you have any of these symptoms resulting from a loss of too much body fluid (dehydration): vomiting, nausea, bloating, dizziness, stomach-area (abdominal) cramping, urinating less often than normal, trouble drinking clear liquids, troubles swallowing, seizures, or heart problems.
- CLENPIQ can cause ulcers of the bowel or bowel problems (ischemic colitis). Tell your healthcare provider right away if you have severe stomach-area (abdominal) pain or rectal bleeding.
- The most common side effects of CLENPIQ in adults include nausea, headache, high magnesium levels in your blood, dehydration or dizziness and stomach area (abdominal) pain. The most common side effects of CLENPIQ in children 9 to 16 years of age include nausea, vomiting and stomach area (abdominal) pain. These are not all the possible side effects of CLENPIQ. Ask your doctor or pharmacist for more information.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

Please see accompanying full Prescribing Information, including Medication Guide, also available at www.CLENPIQ.com.

CLENPIQ® is a registered trademark of Ferring B.V.
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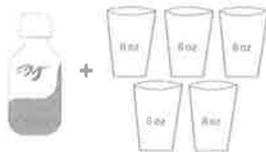
US-CLEN-2000020 v2

FERRING
PHARMACEUTICALS

CLENPIQ®
(sodium picosulfate, magnesium oxide, and anhydrous citric acid) Oral Solution
10 mg/3.5 g/12 g per 160 mL bottle

HOW TO TAKE CLENPIQ:
DRINK, HYDRATE, REPEAT
SPLIT-DOSE REGIMEN

Evening Before
Between 5-9 PM



Drink 5 or more 8 ounce (oz) cups of clear liquids.*
Finish liquids over the next 5 hours.

Morning of
5 hours before procedure

Drink 4 or more 8 ounce (oz) cups of clear liquids.
Finish liquids 2 hours before your colonoscopy or as advised by your doctor.

Hydration is important and it's part of the prep.
Make sure to hydrate before, during, and after the prep.

Prep Assistant

The time of your colonoscopy is ______:______

Complete your prep and all hydration by ______:______

1

ON THE DAY BEFORE THE COLONOSCOPY, stop eating all solid food and dairy, and start hydrating by drinking clear liquids.

2

Evening before your colonoscopy

- [ ] Drink one bottle of CLENPIQ
- [ ] Hydrate

Drink 5 or more 8 ounce (oz) cups of clear liquid.

Start: ______:______

Finish: ______:______

Check off the cups as you go!

3

(5 hours before colonoscopy time)

- [ ] Drink the other bottle of CLENPIQ
- [ ] Hydrate

Drink 4 or more 8 ounce (oz) cups of clear liquid.

Start: ______:______

Finish: ______:______

Check off the cups as you go!

*After your first dose, if severe bloating, swelling, or stomach pain occurs, delay the second dose until the symptoms resolve.
Please see reverse page for additional information about CLENPIQ, the importance of a clear liquid diet, and hydration.

INDICATION

CLENPIQ® is a prescription medicine used by adults and children 9 years and older to clean the colon before a colonoscopy. CLENPIQ cleans your colon by causing you to have diarrhea. Cleaning your colon helps your healthcare provider see the inside of your colon more clearly during your colonoscopy.

IMPORTANT SAFETY INFORMATION

- Do not take CLENPIQ if your healthcare provider has told you that you have serious kidney problems, a blockage in your intestine (bowel obstruction), an opening in the wall of your stomach or intestines (bowel perforation), a very dilated intestine (toxic megacolon), problems with the emptying of food and fluid from your stomach (gastric retention), or an allergy to any of the ingredients in CLENPIQ.
- CLENPIQ and other bowel preparations can cause serious side effects, including serious loss of body fluid (dehydration) and changes in blood salts (electrolytes) in your blood. These changes can cause abnormal heartbeats that may result in death, seizures (this can happen even if you have never had a seizure), or kidney problems. Your chance of having fluid loss and changes in blood salts with CLENPIQ is higher if you have heart problems, have kidney problems, or take water pills or non-steroidal anti-inflammatory drugs (NSAIDS).

See Important Safety Information continued on the back.

Your procedure will be performed by Doctor: ______________________

Address: ______________________

Date of procedure: ______________ Arrive at: ____________ AM/PM

Comments: ______________________

SUTAB®

(sodium sulfate, magnesium sulfate, and potassium chloride) Tablets

1.479 g/0.225 g/0.188 g

On the Day *Before* Your Procedure

What You **CAN** Do

- You may have low residue breakfast. Low residue foods include eggs, white bread, cottage cheese, yogurt, grits, coffee, and tea.
- You may have clear liquids.

What You **CANNOT** Do

- Do not drink milk or eat or drink anything colored red or purple.
- Do not drink alcohol.
- Do not take other laxatives while taking SUTAB.
- Do not take oral medications within 1 hour of starting each dose of SUTAB.
- If taking tetracycline or fluoroquinolone antibiotics, iron, digoxin, chlorpromazine, or penicillamine, take these medications at least 2 hours before and not less than 6 hours after administration of each dose of SUTAB.

Liquids That Are **OK** to Drink

- Coffee or tea (no cream or nondairy creamer)
- Fruit juices (without pulp)
- Gelatin desserts (no fruit or topping)
- Water
- Chicken broth
- Clear soda (such as ginger ale)

Note

- SUTAB is an osmotic laxative indicated for cleansing of the colon in 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. SUTAB 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 SUTAB.
- The most common adverse reactions after administration of SUTAB were nausea, abdominal distension, vomiting, and upper abdominal pain.
- Contact your healthcare provider if you develop significant vomiting or signs of dehydration after taking SUTAB or if you experience cardiac arrhythmias or seizures.
- If you have any questions about taking SUTAB, call your doctor.

To learn more about this product, call 1-800-874-6756.

The Dosing Regimen

SUTAB is a split-dose (2-day) regimen. A total of 24 tablets is required for complete preparation for colonoscopy. You will take the tablets in two doses of 12 tablets each. Water must be consumed with each dose of SUTAB, and additional water must be consumed after each dose.

DOSE 1—On the Day Prior to Colonoscopy

Take the tablets with water

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.

Tablets not shown actual size.

IMPORTANT: If you experience preparation-related symptoms (for example, nausea, bloating, or cramping), pause or slow the rate of drinking the additional water until your symptoms diminish.

Drink additional water

STEP 3 Approximately 1 hour after the last tablet is ingested, fill the provided container again with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

STEP 4 Approximately 30 minutes after finishing the second container of water, fill the provided container with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

DOSE 2—Day of the Colonoscopy

- Continue to consume only clear liquids until after the colonoscopy.
- The morning of colonoscopy (5 to 8 hours prior to the colonoscopy and no sooner than 4 hours from starting Dose 1), open the second bottle of 12 tablets.
- Repeat STEP 1 to STEP 4 from Dose 1.

Tablets not shown actual size.

IMPORTANT: You must complete all SUTAB tablets and required water at least 2 hours before colonoscopy.

Please read the full Prescribing Information and Medication Guide in the kit.

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OFFICE INFORMATION

Procedure date:

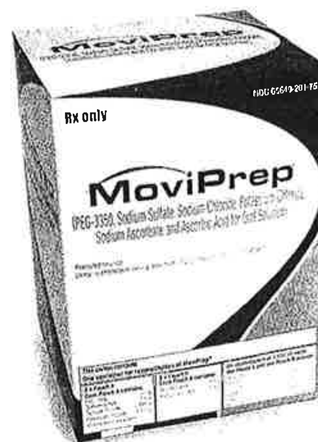
Arrival time:

Location:

Bowel Preparation for Colonoscopy With MoviPrep

Colonoscopy is a routine, generally safe procedure used to examine the colon. There are steps that you, the patient, must take before the procedure to ensure the highest level of safety and effectiveness.

1. Make arrangements to have someone drive you home after the procedure
   - Colonoscopy involves sedation, and you will not be allowed to leave unaccompanied
2. Follow your physician's instructions regarding medicines to avoid and diet to follow before your procedure
3. Finish the entire bowel prep regimen as described on the following page, unless otherwise directed by a physician



MoviPrep is available at most retail pharmacy outlets. If your pharmacy does not have MoviPrep in stock, it can be ordered and delivered within 24 hours.

Information for your pharmacist: NDC 65649-201-75

MoviPrep®

(PEG-3350, Sodium Sulfate, Sodium Chloride, Potassium Chloride, Sodium Ascorbate and Ascorbic Acid for Oral Solution)

www.MoviPrep.com

Important Safety Information about MOVIPREP

MOVIPREP® (PEG-3350, sodium sulfate, sodium chloride, potassium chloride, sodium ascorbate and ascorbic acid for oral solution) is an osmotic laxative indicated for cleansing of the colon as a preparation for colonoscopy in adults 18 years of age or older. MOVIPREP is contraindicated in patients with gastrointestinal (GI) obstruction, bowel perforation, gastric retention, ileus, toxic colitis or toxic megacolon, and patients who have had a severe hypersensitivity reaction to any of its components. MOVIPREP should be used with caution in patients at risk of or with fluid and electrolyte abnormalities, hyponatremia, arrhythmias, seizures, in patients with impaired renal function or patients taking concomitant medications that affect renal function, patients with known or suspected inflammatory bowel disease, patients with suspected GI obstruction or perforation, patients at risk for aspiration, and patients with glucose-6-phosphate dehydrogenase deficiency. Most common adverse reactions for split dosing (incidence ≥ 5%) are malaise, nausea, abdominal pain, vomiting, and upper abdominal pain. The most common adverse reactions for evening only dosing (incidence ≥ 5%) are abdominal distension, anal discomfort, thirst, nausea, abdominal pain, sleep disorder, rigors, hunger, malaise, vomiting, and dizziness. MOVIPREP contains 233 mg of phenylalanine per treatment. Advise patients to hydrate adequately before, during, and after the use of MOVIPREP. Please see accompanying full Prescribing Information for MoviPrep.

Patient Instructions

The MoviPrep carton contains 4 pouches and a disposable container for mixing. You must complete the entire prep to ensure the most effective cleansing.

Beginning at: ___________

STEP 1 MIX FIRST DOSE	■ Empty 1 Pouch A and 1 Pouch B into the disposable container ■ Add lukewarm drinking water to the top line of the container. Mix to dissolve **If preferred, mix solution ahead of time and refrigerate prior to drinking. The reconstituted solution should be used within 24 hours.**
STEP 2 DRINK FIRST DOSE	■ The MoviPrep container is divided by 4 marks. Every 15 minutes, drink the solution down to the next mark (approximately 8 oz), until the full liter is consumed ■ Drink 16 oz of the clear liquid of your choice. This is a necessary step to ensure adequate hydration and an effective prep

A, B, 8 oz, 8 oz

Clear liquids include water, ginger ale, apple juice, Gatorade®*, lemonade, and broth. No red or purple liquids.

Ask your doctor if you have any questions about whether a particular drink is acceptable.

Beginning at: ___________

STEP 3 MIX SECOND DOSE	■ Empty 1 Pouch A and 1 Pouch B into the disposable container ■ Add lukewarm drinking water to the top line of the container. Mix to dissolve **If preferred, mix solution ahead of time and refrigerate prior to drinking. The reconstituted solution should be used within 24 hours.**
STEP 4 DRINK SECOND DOSE	■ The MoviPrep container is divided by 4 marks. Every 15 minutes, drink the solution down to the next mark (approximately 8 oz), until the full liter is consumed ■ Drink 16 oz of the clear liquid of your choice. This is a necessary step to ensure adequate hydration and an effective prep

A, B, 8 oz, 8 oz

A colonoscopy prep causes the body to lose a significant amount of fluid and can result in sickness due to dehydration. It's important that you prepare your body by drinking extra clear liquids before the prep. Stay hydrated by drinking all required clear liquids during the prep. Replenish your system by drinking clear liquids after returning home from your colonoscopy.

If you have any questions, please call our office at ____________________.

MoviPrep®
(PEG-3350, Sodium Sulfate, Sodium Chloride, Potassium Chloride, Sodium Ascorbate and Ascorbic Acid for Oral Solution)

*Gatorade is a registered trademark of Stokely-Van Camp, Inc, Chicago, IL.

Salix Web site: www.salix.com 8510 Colonnade Center Drive, Raleigh, NC 27615 Tel • 866.669.SLXP (7597)
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www.MoviPrep.com