Clear Liquid Diet Instructions

Patient Name:_____ DATE OF PROCEDURE:_____

FACILITY: ***SAN ANTONIO SURG CNTR / SARH / CASA COLINA***

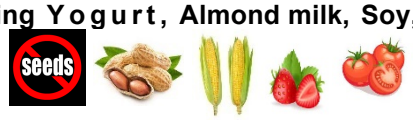
Your clear liquid diet will start the day before your procedure on _____/_____/_____, beginning when you wake up.
NO SOLID FOOD AT ALL DAY THE DAY BEFORE YOUR PROCEDURE!

Examples Of Clear Liquids:

Apple / White grape juice
Lemonade
Water
Gatorade
Clear broth / bouillon
Clear Soda (7-UP, SQUIRT, GINGER ALE)
Coffee & Tea **WITHOUT** creamer
Jell-O Green/Yellow/Orange
Popsicles (green,yellow,orange)

STOP ALL LIQUIDS AT 12AM (MIDNIGHT)

No RED or PURPLE colored liquids! No MILK PRODUCTS! (Including Yogurt, Almond milk, Soy, Coconut etc.)



STARTING 3 DAYS PRIOR NO NUTS/SEEDS OR CORN

If your bowel prep has to be changed for any reason – PLEASE CONTACT THE OFFICE !! IT IS YOUR RESPONSIBILITY TO CONTACT THE OFFICE FOR NEW INSTRUCTIONS.

MEDICATION RESTRICTIONS: ***BLOOD THINNERS, IRON SUPPLEMENT, PHENTERMINE*** **MUST BE STOPPED 1 WEEK (7 DAYS) PRIOR.**

IF A CARDIAC CLEARANCE IS NEEDED, IT MUST BE RECEIVED IN OFFICE ONE WEEK PRIOR TO PROCEDURE.

DIABETIC PATIENTS: During prep day, please only take ½ of your scheduled dose. Insulin needs to be held the day of the procedure.

CANCELLATION: Any procedure needs to be done at least 48 HOURS OR MORE in advance. If you cancel more than two times, we require you to come back to the office for another consultation before we can reschedule any procedure.
CANCELLATION POLICY*:** ***There is a $100.00 fee for procedure no show or canceling less than 48 hours.

A DRIVER WILL BE NEEDED FOR PICK UP AND DROP OFF – NO RIDE SHARES ARE ALLOWED! NO UBER, LYFT OR TAXIS

COVID TEST ARE NOW REQUIRED PRIOR TO ALL PROCEDURES – PLEASE MAKE SURE TO DO IT WITHIN THE REQUIRED TIME FRAME (7 DAYS) OR RESULTS WILL NOT BE RECEIVED ON TIME.

COLON PREP IS ELECTRONICALLY SENT TO YOUR PHARMACY – INSTRUCTIONS ARE INCLUDED WITH YOUR FOLDER.

Your insurance will be verified for any non-preventative procedure. If you have a deductible that has not been met, you will be responsible to pay your portion *PRIOR* to your procedure.

I understand that my procedure is scheduled for _____/_____/_____. I understand that if I DO NOT FOLLOW DIRECTIONS, EAT OR PRESENT MYSELF AT AN INORRECT TIME/DATE, MY PROCEDURE *MAY NOT* BE PERFORMED.

I have read and understand the above instructions for my procedure. I understand that I will be held responsible for any cancellation or no-show fees if I don't not follow these instructions.
PATIENT INITIALS: _____

SCHEDULED VIA TELEHEALTH. ***PATIENT ADVISED TO COME IN AND PICK UP FOLDER.***
EMP INITIALS: _____ Date: ____/_____/_____