Allergies/Reactions: Provider Sign 2017-2003 Payoling Influsion Controls - Foux 253-697-6006 Payoling Influsion Services - Foux 253-697-6006 Payoling Influsion Services - Foux 253-697-6007 Payoling Influsion Services - Foux 253-697-600		ALL OR	DERS MUST BE SIGNED, DATED A	AND TIMED BY	PHYSICIAN		
Autominition Services - Face 253 876 8282 Morth's Spotance Influsion Center - Face 259 8232 2531 ORDERS WITH CHECK BOXES White an orader is applicated (phose with check to boxes), physicians are responsible for indicating a check mork in the box nest to the reduct Credent felt uncheaded will not be influenced. Patient Name:	Allergies/Reactions:		☐ Puyallup Infusion Center - Fax: 253-697-5066		☐ Gig Harbor Infusion Services - Fax: 253-530-8069		
ORDERS WITH CHECK BOXES			☐ Allenmore Ambulatory Infusion Services - Fax: 253-864-40		2 DHEC Infusion Center - Fax: 509-755-5845		
Patient Name:			I .		•		
Patient Name:	ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.						
Diagnosis: CIDP (chronic inflammatory demyelinating polyneuropathy)							
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Diagnosis: CIDP (chronic inflammatory demyelinating polyneuropathy) Immune thrombocytopenia) Immune thrombocytopenia) Impogrammaglobulinemia Immune Globulin (IVIG) Dose: Rounded to nearest 5 gm, inflused per MHS IVIG guidelines Impose M	Date of Birth	I / / / /	_ ratient rione Number. (iviay leave message	
TP (immune thrombocytopenia)	Diganosis:	□ CIDP (chronic inflammator	v demvelinating polyneuropathy)		-		
Guillain-Barre (failed plasmapheresis)	Diagnosis.						
Hypogrammaglobulinemia			·				
Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs **If required documentation not received with order, scheduling of treatment will be delayed until complete information is available** Baseline Labs Required: • CBC/CMP Maintenance Labs Required: • CBC/CMP every 6 months If IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal. Patient actual weight =		☐ Hypogammaglobulinemia					
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Maintenance Labs Required: CBC/CMP every 6 months N Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal. Patient actual weight = Ib/kg (required)	**If required documentation not received with order, scheduling of treatment will be delayed until complete information is available**						
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Provider Signature Print Name Date Time	· · · · · · · · · · · · · · · · · · ·						
	Was consent obtained: ☐ Yes ☐ No (if yes, please send DOCUMENTATION of consent with order)						
Another brand of drug, identical in form and content, may be dispensed unless checked Orders expire in 12 months**	Provider Sign	ature	Print Name		Date	Time	
	Another bran	d of drug, identical in form and c	content, may be dispensed unless check	ed 🗖	Orders e	expire in 12 months**	

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order IMMUNE GLOBULIN (IVIG)

MultiCare 🕰

