Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Phlebotomy Order (Revised 12/11/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
☐ NKDA		

Diagnosis:

☐ ICD-10:

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☐ Hold treatment and notify provider IF:
- HCT LESS THAN 45% (men);
- HCT LESS THAN 42% (women).

☐ Hold treatment and notify provider IF:
- Hemoglobin LESS THAN 12g/dL;
- Previous Ferritin LESS THAN 10ng/mL;
- Previous Transferrin Sat LESS THAN 50%

Nursing Communication:

☑ Start PIV/Access CVC and flush device per Atrium Health Protocol.

☑ Obtained vital signs PRE- and POST- therapeutic phlebotomy.

Hydration:

☐ Sodium Chloride 0.9% 500mL bolus IV over 30mins. PRE-hydration.

☐ Sodium Chloride 0.9% 500mL bolus IV over 30mins. POST-hydration.

Infusion Therapy:

Therapeutic Phlebotomy

☑ Volume to be removed: 500mL

Frequency: _____

Hypersensitivity Protocol:

☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: