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

Thymoglobulin® (Anti-thymocyte Globulin) Infusion Order (Revised 11/7/2025)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
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:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	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

Nursing Communication:

- ☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.
- ☑ Obtain vital signs to include Blood Pressure, Heart Rate AND Temperature PRE- and POST- treatment and every hour during infusion.
- ☑ Monitor patient for signs of reaction for 30mins AFTER completion of 1st infusion and subsequent infusions PRN IF previous signs of reaction observed.

Pre-Medications: (Administer 60 minutes PRIOR to treatment)

- ☐ Acetaminophen (Tylenol) 650mg PO ONCE
- ☐ Diphenhydramine (Benadryl) 25mg PO ONCE
- ☐ Diphenhydramine (Benadryl) 25mg IV ONCE
- ☐ Loratadine (Claritin) 10mg PO ONCE
- ☐ Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

- ☑ Anti-thymocyte Globulin (Thymoglobulin) - Heparin 1000 Units - Hydrocortison Sodium Succinate 20mg in NS (Treatment Plan) 1.5mg/kg IV over 4 hours.
  Frequency:

Supportive Care Medications:

- ☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.
- ☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
- ☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

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: