## DOCTOR’S ORDERS

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

### DATE:

### TREATMENT:

- **[]** imiquimod 5% cream Pump
  - Mitte: _____ pump(s) (7.5gram/pump) Repeat: __________

- OR

- **[]** imiquimod 5% cream Packets
  - Mitte: _____ box(s) (24 packets/box) Repeat: __________

**Directions for topical application:**

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### RETURN APPOINTMENT ORDERS

- **[]** Return in ______ week(s) for Doctor and treatment.

- **[]** Return in ______ week(s) for assessment.

- **[]** Other tests:

- **[]** Consults:

- **[]** See general orders sheet for additional requests.

### DOCTOR’S SIGNATURE:

**SIGNATURE:**

**UC:**

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*Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at [www.bccancer.bc.ca](http://www.bccancer.bc.ca) and according to acceptable standards of care.*