**PROTOCOL CODE: SMPDT (topical)**

Order must be filled at the BC Cancer Agency Vancouver Centre Pharmacy.

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht________ cm</th>
<th>Wt________ kg</th>
<th>BSA________ m²</th>
</tr>
</thead>
</table>

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

**DATE:**

**TREATMENT:**

- ☐ Methyl aminolevulinate (METVIX™) cream for treatment on ________________ (date).
  - Mitte: _______  Repeat: _______

  OR

- ☐ Aminolevulinic Acid (LEVULAN KERASTICK®) for topical solution, 20% for treatment on ________________ (date).
  - Mitte: _______  Repeat: _______

☐ Other Tests: _________________________________________________________

☐ Consults: ____________________________________________________________

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**