

PROSTHETICS

DENTIST NAME _____ ADDRESS _____ _____ POSTCODE _____ PHONE _____ EMAIL _____		JOB NO. Lab use only																																									
PATIENT NAME _____ <input type="checkbox"/> MALE AGE _____ <input type="checkbox"/> FEMALE		STANDARD REQUIRED <input checked="" type="checkbox"/> Please tick <input type="checkbox"/> PREMIER PLUS <input type="checkbox"/> PREMIER <input type="checkbox"/> INDEPENDENT																																									
TOOTH SELECTION <input type="checkbox"/> ENIGMA <input type="checkbox"/> IVOCLAR <input type="checkbox"/> OTHER PLEASE STATE _____		SERVICE REQUIRED <input type="checkbox"/> NORMAL - 5 WORKING DAYS IN THE LAB <input type="checkbox"/> SWIFT - 4 WORKING DAYS IN THE LAB +15% <input type="checkbox"/> EXPRESS - 3 WORKING DAYS IN THE LAB +25% <input type="checkbox"/> SPRINT - 2 WORKING DAYS IN THE LAB +50% <input type="checkbox"/> SUPER SPRINT - 1 WORKING DAY IN THE LAB +100% <small>Please allow 10 days @ bite/try-in for CO / CR and 10 days @ finish for Valplast.</small>																																									
<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> EXTRACTIONS <input type="checkbox"/> HIGH IMPACT ACRYLIC <input type="checkbox"/> CO / CR <input type="checkbox"/> VALPLAST		MOULD _____ SHADE _____																																									
NOTATION <table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 2px;">18 17 16 15 14 13 12 11</td> <td style="padding: 2px;">21 22 23 24 25 26 27 28</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">48 47 46 45 44 43 42 41</td> <td style="padding: 2px;">31 32 33 34 35 36 37 38</td> </tr> </table>		18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28	48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%;">DATE</th> <th style="width: 10%;">TECHNICIAN</th> </tr> </thead> <tbody> <tr><td>UPPER SPECIAL TRAY</td><td></td><td></td></tr> <tr><td>LOWER SPECIAL TRAY</td><td></td><td></td></tr> <tr><td>BITE</td><td></td><td></td></tr> <tr><td>TRY IN</td><td></td><td></td></tr> <tr><td>RE-TRY</td><td></td><td></td></tr> <tr><td>FINISH</td><td></td><td></td></tr> <tr><td>CO / CR</td><td></td><td></td></tr> <tr><td>RELINE (HARD)</td><td></td><td></td></tr> <tr><td>RELINE (SOFT)</td><td></td><td></td></tr> <tr><td>ADDITION</td><td></td><td></td></tr> <tr><td>REPAIR</td><td></td><td></td></tr> </tbody> </table>			DATE	TECHNICIAN	UPPER SPECIAL TRAY			LOWER SPECIAL TRAY			BITE			TRY IN			RE-TRY			FINISH			CO / CR			RELINE (HARD)			RELINE (SOFT)			ADDITION			REPAIR		
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ESSENTIAL REQUIREMENTS NOT MET		FINAL INSPECTION SIGNATURE																																									
FOR SURGERY USE DISINFECTED		<small>This is a custom-made medical device that has been manufactured to satisfy the design characteristics and properties specified by the prescriber for the above-named patient. This medical device is intended for exclusive use by this patient and conforms to the general safety and performance requirements specified in Annex I of the Medical Devices Regulations.</small>																																									
Feedback: To enable our dental laboratory to comply with the Medical Devices Regulations for Post Market Surveillance, please inform us of any feedback or issues regarding the enclosed device(s) as soon as possible.		ITEMS DISPATCHED SILICONE <input type="checkbox"/> U <input type="checkbox"/> L ALGINATE <input type="checkbox"/> U <input type="checkbox"/> L STUDY MODELS <input type="checkbox"/> U <input type="checkbox"/> L BITE <input type="checkbox"/> DENTURE <input type="checkbox"/> U <input type="checkbox"/> L EMAIL <input type="checkbox"/> PHOTO <input type="checkbox"/>																																									

