



NHS PRIVATE

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THIS SECTION MUST BE COMPLETED TO FULFIL YOUR ORDER			
Doctor's Name:		Email:	
Address:		Phone:	
.....		Post Code:	
Case Number (Lab use only):	Box Number (Lab use only):	Patient Name:	
<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		
Return Date: Allow 14 days from receipt	<input style="width: 20px; height: 20px;" type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Age:	<input style="width: 20px; height: 20px;" type="text"/>
		Date received by Lab	<input style="width: 20px; height: 20px;" type="text"/>

TYPE OF RESTORATION		
<input type="checkbox"/> PFM	<input type="checkbox"/> Full Cast	<input type="checkbox"/> Metal Free
<input type="checkbox"/> Non-Precious	<input type="checkbox"/> Denture	
<input type="checkbox"/> Semi-Precious	<input type="checkbox"/> Zirconia	
<input type="checkbox"/> Precious (Yellow or White)	<input type="checkbox"/> Composite	
<input type="checkbox"/> Gold	<input type="checkbox"/> Emax	
<input type="checkbox"/> Captek	<input type="checkbox"/> Other	

LENGTH OF CENTRALS TO SOFT TISSUE ZENITH	
Left Central	Special Length Instructions
.....
Right Central
.....

SERVICE DESIRED		
<input type="checkbox"/> Single Unit Crown	<input type="checkbox"/> Splinted Crowns	<input type="checkbox"/> Bridge
<input type="checkbox"/> Maryland Bridge	<input type="checkbox"/> Veneer	<input type="checkbox"/> Inlay/Onlay
<input type="checkbox"/> Post and Core	<input type="checkbox"/> Post Crown	<input type="checkbox"/>

STUMP SHADE
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PORCELAIN BUTT MARGIN	
<input type="checkbox"/> 360°	<input type="checkbox"/> Buccal Only

TOOTH NUMBER	SHADE

PONTIC DESIGN	
<input type="checkbox"/> Full Ridge	
<input type="checkbox"/> Modify Ridge Lap	
<input type="checkbox"/> No Contact	
<input type="checkbox"/> Point Contact	
<input type="checkbox"/> Point in Socket (Ovate)	
<input type="checkbox"/> Show Metal Strip on Lingual <input type="checkbox"/> No Metal Strip on Lingual	

SPECIAL INSTRUCTIONS
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OCCLUSAL CONTACT		
<input type="checkbox"/> No Contact	<input type="checkbox"/> Light Contact	<input type="checkbox"/> Full Contact

OCCLUSAL STAINING			
<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Medium	<input type="checkbox"/> Heavy

INCISAL TRANSLUCENCY		
<input type="checkbox"/> Minimal	<input type="checkbox"/> Normal	<input type="checkbox"/> See Diagram

SURFACE TEXTURE			
<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

SURFACE LUSTRE		
<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High

This/the devices conform to the relevant essential requirements set out in Annex 1 of the Medical Devices Directive 93/42/EEC. This/the custom made devices are for the exclusive use of the patients named above and have been prescribed by the dental practitioner (some work may have been requested solely or in part by a GDC registered dental technician). In partnership with BQSDENT.