Comprehensive Laboratory Communication Document

Please make a copy for your records and send original back with case each time

PATIENT NAME: _____ **DOCTOR:**_____
Personal Info: M/F: _____

Case Type: ☐ **NM** ☐ **CO** ☐ **Fixed** ☐ **Fixed/Removable** ☐ **Carp Style**

1. SMILE DESIGN

Patient's desires: _____

Doctor's comments: _____

Aesthetic Changes: ☐ **Add length** _____**mm** ☐ **Add fullness**_____ ☐ **Other:**_____

Aesthetic Limitations: ☐ **None** ☐ **Excess display of Ant teeth** ☐ **Excess display of Gingival tissue** ☐ **Severe Asymmetry**

Does patient show gumline when smiling? Yes No Comments: _____

Finished Shade: _____
General shape: _____
Incisal edge shape: _____
Incisal edge translucency: _____
Halo: _____
Coloration: _____
Surface contour: _____

BITE MANAGEMENT (All CASES)

RIGHT ___/___ **ANT** ___/___ **LEFT** ___/___

FILL IN AS VERIFIED	DR	LAB	DR	LAB	DR	LAB
CO:						
NM Bite:						
Bite Transfer Stint						
Wax up:						
*Die Models:						
Finished Porcelain:						
Finished Case:						

***Gum line changed: add** _____**mm to anterior measurement (tooth #**_____**)**

Dr:_____

Patient:_____

Central Length:
Natural (#8_____ #9_____) **Wax Up (#8_____ #9_____)** **Final Restorations (#8_____#9_____)**

2. DIAGNOSTIC PHASE

Dr Sends/Requests	Verified by Dr/Office	Completed/Signed by Lab
☐ Upper model/impression		
☐ Lower model/impression		
☐ Inter-occlusal Bite		
☐ Fox Index		
☐ Photos:		
☐ Other:		

Return To Us	Completed/Signed by Lab	Verified by Dr/Office
☐ Upper wax up/shim		
☐ Lower wax up/shim		
☐ Adjust gum line to ideal Mark this in Red on Model		
☐ Surgical Template		
☐ Duplicate Guidance Return Guide Table		
☐ Dual arch shim		
☐ Dual arch carp shim		
☐ Cranial base transfer		
☐ Bite transfer		
☐ Do Not wax up to the gumline		
☐ Duplicate upper & mount		
☐ Duplicate Lower & mount		
☐ Acculiner/upper/fox		
☐ Stratus inter-occlusal		
☐ Other:		

Additional Instructions:

_____

_____

_____

Due Date: _____ By Noon

Dr. Signed _____

Lab Diagnostic Wax-Up Comments

_____

_____

3. PREP APPOINTMENT

Dr._____

Patient:_____

Bite Shim (Ant measurement only): dry:_____ Wash 1:____ Wash 2:____ Wash 3:____ Wash 4:_____

□ Shade:_____ □ Shade to Follow Date: _____

□ Stump Shade:_____

Dr Sends	Verified by Dr/Office	Completed/Signed by Lab
□ Upper Final Impression		
□ Lower Final Impression		
□ Bite Transfer		
□ Cranial Base Transfer		

Final porcelain types:

□ Empress _____ □ Emax _____
□ Cercon _____ □ PFM _____
□ ERA Attachments _____

Dr Instructions	Confirmed by Lab	Verified by Dr/Office
□ Duplicate wax up		
□ Duplicate plus minor changes (see below) Date:		
□ Corrected temp model to follow Date:		

□ RETURN ALL STUMPS THAT PORCELAIN WAS MADE ON FOR SHADE VERIFICATION □

Additional Instructions

_____

_____

_____

_____

Due Date:_____ By Noon

Dr Signed: _____

4. CASE VERIFICATION PHASE

LAB	DOCTOR/(Comments)	
_____	_____	Prescription Followed
_____	_____	Upper Model Mounted to Crainal Base
_____	_____	Lower Model Mounted to Correct Bite Management
_____	_____	Margins indicated in red
_____	_____	Marginal Fit
_____	_____	Emergence Profile
_____	_____	Contours of Porcelain as related to Wax-Up or Instructions
_____	_____	Occlusion
_____	_____	Duplicate Guidance
_____	_____	Interproximal Contacts
_____	_____	Shade Check via Stumps (check porc. margins of PFMs for opacity)

Dr:_____Patient:_____

5. CEMENTATION FEEDBACK

Color:_____

Margins:_____

Contours:_____

Contacts:_____

Occlusion:_____

Patient's Response:_____

Dr's Response:_____

Team Response:_____