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

<table>
<thead>
<tr>
<th>Dr Sends/Requests</th>
<th>Verified by Dr/Office</th>
<th>Completed/Signed by Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper model/impression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower model/impression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inter-occlusal Bite</td>
<td></td>
<td></td>
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<tr>
<td>Fox Index</td>
<td></td>
<td></td>
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<tr>
<td>Photos:</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

Return To Us

☐ 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: __________________________________________

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<tbody>
<tr>
<td>☐ Upper Final Impression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Lower Final Impression</td>
<td></td>
<td></td>
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<tr>
<td>☐ Bite Transfer</td>
<td></td>
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<tr>
<td>☐ Cranial Base Transfer</td>
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</tr>
</tbody>
</table>

Final porcelain types: ☐ Empress ______________________ ☐ Emax ______________________

☐ Cercon ______________________ ☐ PFM ______________________

☐ ERA Attachments ______________________

<table>
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<tr>
<th>Dr Instructions</th>
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<tbody>
<tr>
<td>☐ Duplicate wax up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Duplicate plus minor changes (see below) Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Corrected temp model to follow Date:</td>
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</tr>
</tbody>
</table>

☐ 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 PFM s for opacity)

Dr: ___________________________ Patient: ___________________________
5. CEMENTATION FEEDBACK

Color: 

Margins: 

Contours: 

Contacts: 

Occlusion: 

Patient’s Response: 

Dr’s Response: 

Team Response: 