REMOVABLE RESTORATIONS RX

Lab Name:

Your Reference #_____

Doctor_____

Patient Name_____

Date Sent _____**Due Date**_____

PROLAB SOLUTIONS, INC.

1 Connelly Rd P.O. Box 506 Emigsville, PA 17318

Phone: 888-776-5229 Fax: 717-384-6087

PARTIAL DENTURES

PARTIALS WITH FRAMES

☐ CoCr ☐ Vitallium

- ☐ FRAME ONLY
- ☐ FRAME BITE BLOCK/RIM
- ☐ FRAME W/TEETH SET UP
- ☐ FRAME/SETUP/FINSH
- ☐ RESET TEETH ONLY
- ☐ PROCESSING

TYPE OF ACRYLIC

- ☐ CONVENTIONAL
- ☐ LUCITONE 199
- ☐ VALPLAST

PARTIALS ALL ACRYLIC

- ☐ TEETH SET UP FINISH ALL ACRYLIC
- ☐ WAX TRY-IN ALL ACRYLIC
- ☐ PROCESSING ALL ACRYLIC
- ☐ ADD TOOTH ALL ACRYLIC
- ☐ RESET TEETH ALL ACRYLIC

TYPE OF ACRYLIC

- ☐ CONVENTIONAL
- ☐ LUCITONE 199
- ☐ VALPLAST
- ☐ FRS

OTHER

- ☐ ADD TOOTH(2916) #_____
- ☐ ADD WIRE CLASP #_____
- ☐ ADD CAST CLASP #_____
- ☐ VALPLAST CLASP #_____
- ☐ CLEAR CLASP #_____

Items Sent: ***(Circle all that apply)***

Single Tray	Triple Tray	Study Model
Upper Model	Lower Model	Bite Block
Bite	Wax with Teeth	Articulator
	Frame	

Other_____

FRAMEWORK DESIGN

- ☐ LAB TO DESIGN
- ☐ SEE DRAWING ON RX
- ☐ SEE DRAWING ON CAST

TOOTH SHADE _____

ACRYLIC SHADE _____

- ☐ MESIAL REST(S) ON_____
- ☐ DISTAL REST(S) ON_____
- ☐ CINGULUM REST(S) ON _____

FULL DENTURES

FULL DENTURES

- ☐ SET TEETH TRYIN (2012)
- ☐ PROCESSING (2013)
- ☐ SET TEETH & PROCESS (2011)
- ☐ SET TEETH & PROCESS(2014) W/Lucitone 199
- ☐ PROCESS W/LUCITONE(2015) W/Lucitone 199
- ☐ TCS SUCTION CUP

IMMEDIATE DENTURES *(Extract All Teeth)*

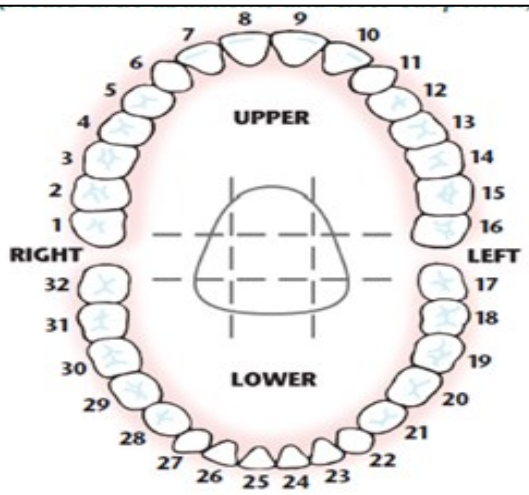
- ☐ IMMEDIATE TEETH SET UP FINISH (2151)
- ☐ IMMEDIATE WAX TRY-IN (2152)

TYPE OF ACRYLIC

☐ CONVENTIONAL ☐ LUCITONE 199

OTHER

- ☐ OCCLUSAL SPLINT(2918)
- ☐ SURGICAL STENT(2919)
- ☐ BLEACHING TRAY(2923)
- ☐ CUSTOM IMPRESSION TRAY(2924)
- ☐ DUPLICATE MODEL(2935)
- ☐ RESET TEETH
- ☐ NESBIT DIRECT FINISH(2131)
- ☐ ACRYLIC FLIPPER(2171)
- ☐ SPACE MAINTAINER(2909)
- ☐ BASE PLATE/BITE RIM(2911)
- ☐ NIGHT GUARD SOFT(2921)
- ☐ NIGHT GUARD HARD(2922)



SELECT WORK TO BE MADE

UPPER **LOWER**

_____

OTHER SPECIAL INSTRUCTIONS

REMAKE INFORMATION

(Please complete this section if returning this case for a remake)

Customer Original Pan #_____PLS Original RX #_____

Reason for Remake_____

_____

Items being Returned

☐ Original Prosthesis (Partial, Bite, Etc.)

☐ Original Model	Original Die	Original PLS RX
☐ Old Impression	New Impression	Study Model

(Failure to provide original RX, reason, or items may result in a delay in processing this case and a charge for this remake)