



Turner Dental Laboratory Ltd.

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WORK ORDER NUMBER _____ DATE _____

DR. _____

ADDRESS _____

CITY AND PROVINCE _____

PATIENT'S NAME _____ MALE FEMALE

TYPE OF RESTORATION _____

DENTURE

MX

MD

PARTIAL DENTURE

MX

MD

IMMED. DENTURE

MX

MD

DATED WANTED: TRY IN _____ FINISH _____

MOULD AND SHADE SPECIFICATION

PORCELAIN - SHADE	MOULD	ANTERIOURS		POSTERIOURS	
		PLASTIC - SHADE	MOULD		
BIOBLEND _____	_____	BIOBLEND _____	_____	<input type="checkbox"/> RATIONAL	
BIOFORM _____	_____	BIOFORM _____	_____	<input type="checkbox"/> FUNCTIONAL	
OTHER _____	_____	PORTRAIT _____	_____	<input type="checkbox"/> TWENTY DEGREE (20°)	
_____	_____	IVOCLAR _____	_____	<input type="checkbox"/> THIRTY-THREE DEGREE (33°)	
_____	_____	ARTIC _____	_____	<input type="checkbox"/> PILKINGTON-TURNER (30°)	
_____	_____		_____	<input type="checkbox"/> ORTHOSIT	
_____	_____		_____	<input type="checkbox"/> ORTHOTYP	

INSTRUCTIONS (DO NOT SUBSTITUTE PRODUCT, MOULD, OR SHADE WITHOUT APPROVAL)

DENTIST'S LICENSE NUMBER _____ DATE THE _____ DAY OF _____

PERSONAL SIGNATURE OF DENTIST