MILL AXIS
A DEH STANDARD

MillAxis DENTAL LAB

Lot 17, 18, 19, Damai Plaza Phase 4,
Luyang 88300 Kota Kinabalu, Sabah
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WORK ORDER / PRESCRIPTION FORM

Work Order No.: _____
Date Received: _____
Date Required: _____

1. REFERRING CLINIC & DOCTOR

Clinic Name: _____
Dentist Name: _____
Contact No.: _____

2. PATIENT INFORMATION

Patient Name: _____
Age: _____
Gender: ☐ Male ☐ Female ☐ Other

3. PROSTHESIS TYPE (Tick one or more)

☐ Crown & Bridge ☐ Implant Crown / Bridge
☐ Complete Denture (Upper / Lower)
☐ Removable Partial Denture (Upper / Lower)
☐ Other: _____

4. CROWN & BRIDGE (Complete if applicable)

Tooth Number(s) (FDI): _____

Restoration Type:
☐ Zirconia Monolithic ☐ Zirconia Layered
☐ PFM ☐ Full Metal
☐ PMMA Temporary ☐ Other: _____

Pontic Design (if bridge):
☐ Ridge Lap ☐ Modified Ridge Lap
☐ Ovate ☐ Hygienic

Occlusal Contact:
☐ Light ☐ Normal ☐ Heavy

Margin Design:
☐ Feather ☐ Chamfer ☐ Shoulder

5. DENTURE (Complete if applicable)

Type:
☐ Complete Upper ☐ Complete Lower
☐ RPD Upper ☐ RPD Lower

Acrylic Base Colour / Tissue Shade: _____

Tooth Mould / Size Preference: _____

RPD Framework: ☐ Yes ☐ No
If Yes, Clasp Design / Notes: _____

Special Instructions
(e.g. flange extension, copy denture): _____

6. IMPLANT PROSTHETICS (Complete if applicable)

Implant System / Brand: _____
Platform Size: _____

Connection Type:
☐ Internal Hex ☐ External Hex
☐ Conical

Restoration Type:
☐ Screw-Retained ☐ Cement-Retained

Abutment:
☐ Stock ☐ Custom

Tooth Number(s) (FDI): _____

7. SHADE PRESCRIPTION

(For all tooth-coloured restorations)

Shade Guide Used:
☐ VITA Classical ☐ VITA 3D-Master
☐ Ivoclar Chromascop ☐ Other: _____

Body Shade: _____
Cervical Shade: _____
Incisal / Occlusal Shade: _____
Characterisation Notes (staining, translucency, special effects): _____

Shade Photo Enclosed: ☐ Yes ☐ No

8. MODEL & IMPRESSION DETAILS

Upper Model: ☐ Enclosed ☐ Not Required
Lower Model: ☐ Enclosed ☐ Not Required
Bite Registration: ☐ Enclosed ☐ Not Required

Impression Material Used: _____

Scan File: ☐ STL Enclosed ☐ Sent Digitally

File Format / Notes: _____

9. TRY-IN / DELIVERY

Try-in Required:
☐ Yes ☐ No

Try-in Date: _____

Final Delivery Date Requested: _____

Rush Case:
☐ Yes ☐ No

10. SPECIAL INSTRUCTIONS

_____
_____
_____

11. AUTHORISATION

Dentist Signature: _____
Date: _____

Lab Received By: _____
Date: _____

LAB USE ONLY

Case No.: _____
Received By: _____ Date: _____
Notes: _____

QC CHECK

☐ Framework Fit ☐ Shade Match
☐ Contacts / Occlusion ☐ Other: _____

QC By: _____ Date: _____
Notes: _____

THANK YOU FOR CHOOSING MillAxis DENTAL LAB.
WE APPRECIATE YOUR TRUST AND PARTNERSHIP.

BY DENTIST, FOR DENTIST.