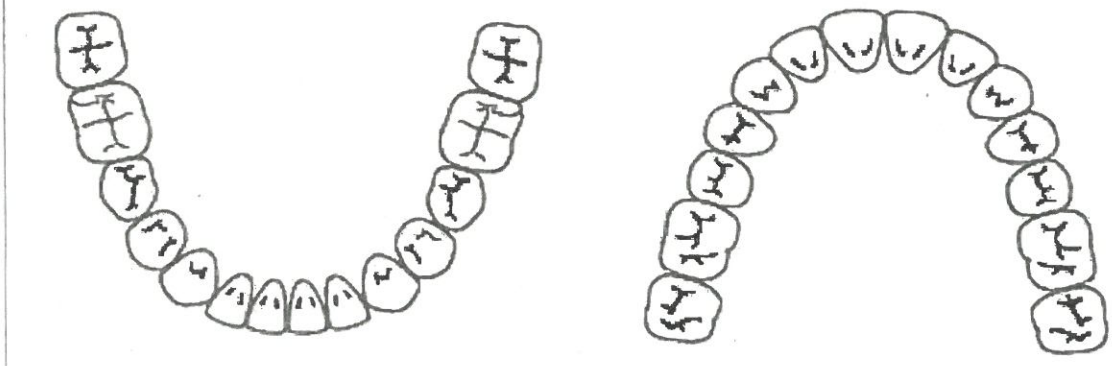
ORAL HEALTHCENTRE OF WESTERN AUSTRALIA	**Form 26** **Indirect Restorative Procedure Outline**	**Use Patient Barcode Label** Given Name _____ Surname _____ DOB _____ TEMP _____

Clinician Signature:	Clinician ID:	Date:
Procedure:		

Diagram



Procedure description: _____

Form 26

Form 26 Indirect Restorative Procedure Outline *continuation*

Form 26

Stage	Date, Signature and clinical code (2 signatures required)	
DISCUSSION (design, abutments and mounting needs)		CC:
FORM 26 signed		
SP TRAYS and FINAL IMPRESSION		
MMR		
TRY IN		
INSERTION		

Procedure Outline Authorised by:	Clinician ID:	Date: