Southern Cross Dental | invisalign®

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PRESCRIPTION & DIAGNOSIS

Account Number ☐☐☐☐☐

Dentist ____________________ Invoice Name ____________________

Invoice Address ____________________ Suburb __________ Postcode __________

Tel ____________________ Email ____________________

Patient ID ____________________ Date ____________________

Patient ID - Please do not use patient's name unless consent is provided, and appropriate form/s have been completed.

Patient D.O.B ____________________

1. INVISALIGN TREATMENT

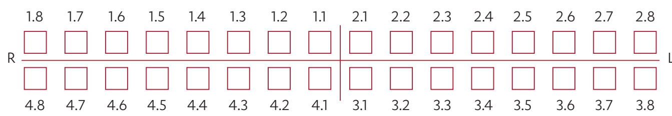
- ◯ Express (7-stage)
- ◯ Moderate (26-stage)
- ◯ Lite (14-stage)
- ◯ Comprehensive (3 Additional Aligners, 3 Years)
- ◯ Comprehensive (Unlimited, 5 Years)

2. TREATED ARCHES

◯ Upper Only ◯ Lower Only ◯ Both

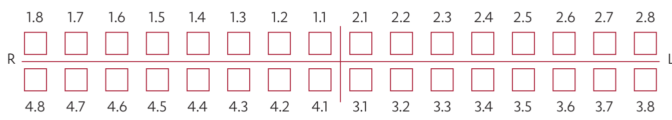
3. TOOTH MOVEMENT RESTRICTION

Do not move these teeth:
(Note: bridges, ankylosed teeth or implants not to be moved)



4. DO NOT PLACE ATTACHMENTS ON THESE TEETH

(Note: crowns, labial or buccal restorations)



5. ANTERIOR - POSTERIOR (A-P) RELATIONSHIP

	Right	Left
◯ Maintain	◯	◯
◯ Improve canine relationship only	◯	◯
◯ Improve canine & molar relationship up to 4 mm	◯	◯
◯ Correction to Class I (canine & molar)	◯	◯
◯ Distalisation (up to 2 mm, without elastics)	◯	◯

6. OVERJET UPPER

- ◯ Show resulting after alignment
- ◯ Maintain initial (may require IPR)
- ◯ Improve resulting

7. OVERBITE

- ◯ Show resulting after alignment
- ◯ Maintain initial (may require IPR)
- ◯ Improve resulting

8. BITE RAMPS

- ◯ None
- ◯ Place Bite Ramps on lingual of these upper teeth

Incisors

- ◯ Central incisors ◯ Lateral incisors
- ◯ Note: Placement of Bite Ramps will take the place of the upper anterior intrusion features (pressure areas) if applicable.

◯ **Canines**

9. MIDLINE CHANGE: RECOMMENDED LIMIT <2MM

- ◯ Maintain **Upper**/MOVE ◯ Right ◯ Left ◯ 1-2mm
- ◯ Maintain **Lower**/MOVE ◯ Right ◯ Left ◯ 1-2mm

Cancellation fee applies once the case has been submitted to Align Technology.
Please contact SCD Invisalign Department for the latest fee charges on **02 8062 9810**
or email: **invisalign@scdlab.com**

10. SPACING RESOLUTION

Upper

- ◯ Close all spaces
- ◯ Leave space/s, specify where ____________________

Lower

- ◯ Close all spaces
- ◯ Leave space/s, specify where ____________________

11. CROWDING RESOLUTION

Upper			
Procline:	◯ Primarily	◯ As needed	◯ None
Expand:	◯ Primarily	◯ As needed	◯ None
IPR Anterior:	◯ Primarily	◯ As needed	◯ None
IPR Posterior Right:	◯ Primarily	◯ As needed	◯ None
IPR Posterior Left:	◯ Primarily	◯ As needed	◯ None

Lower			
Procline:	◯ Primarily	◯ As needed	◯ None
Expand:	◯ Primarily	◯ As needed	◯ None
IPR Anterior:	◯ Primarily	◯ As needed	◯ None
IPR Posterior Right:	◯ Primarily	◯ As needed	◯ None
IPR Posterior Left:	◯ Primarily	◯ As needed	◯ None

12. COMPLIANCE INDICATOR

- ◯ Yes (fee applies)
- ◯ No

ADDITIONAL INSTRUCTIONS

CASE CHECK LIST

- ◯ Upper intra oral scan
- ◯ Lower intra oral scan
- ◯ Upper PVS Impression
- ◯ Lower PVS Impression
- ◯ OPG
- ◯ Lateral Ceph
- ◯ 8 Clinical Photos

COMPATIBLE SCANNER BRANDS

Compatible brands excepted with Invisalign

- ◯ iTero
- ◯ 3M True Definition
- ◯ Dentsply Sirona CEREC Omnicam
- ◯ 3Shape Trios 3

(Contact SCD Invisalign Team for further information)

Please ensure all of the above are submitted to SCD Invisalign to process your case.

By submitting this form, you agree to the terms and conditions, which can be found on our website scdlab.com