



# FUNCTIONAL ORTHOTIC DESIGN

## Functional Orthotic Design

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DOCTOR: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY AND STATE: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

### ACRYLIC

SHADE: \_\_\_\_\_ MOULD: \_\_\_\_\_

TRAY \_\_\_\_\_ DATES \_\_\_\_\_

BITE \_\_\_\_\_

TRY IN \_\_\_\_\_

RETRY \_\_\_\_\_

FINISH \_\_\_\_\_

### CROWN + BRIDGE

VMK

ZIRCONIA

OTHER

please specify \_\_\_\_\_

DATE \_\_\_\_\_ Shade & Design Overleaf

### CHROME CASTING

UPPER

LOWER

OTHER

please specify \_\_\_\_\_

DATE \_\_\_\_\_ Design Overleaf

## INSTRUCTIONS

**SHAUN STRANG**

0451 307 899

