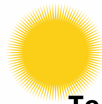
CREHS Inc

DIGITAL SOLUTIONS IN HEALTH SERVICES

Centre for Rehabilitation and Health Services



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Tel: 905-451-5979; Fax: 905-451-4212
info@crehsinc.com; www.crehsinc.com

Dr. ______________________________ Date: __________

Office Name / Address ______________________________

Date Required: ______________________ Time: __________

Patient Name: ______________________________

Restorations *(precise instructions below)*:

☐ Crown
☐ Bridge
☐ Maryland Bridge
☐ Veneer
☐ Inlay/Onlay
☐ Custom Tray

☐ Zirconia ☐ PFM ☐
☐ Provisional (Temporary)
☐ E-Max
☐ Implant
☐ Surgical Stent
☐ Bite Block

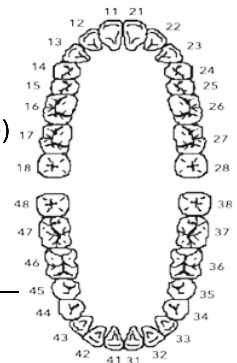
☐ *Denture:* ☐ *Full* ☐ *Acrylic Partial* ☐ *Cast Partial* ☐ *Flipper* ☐ *Relines* ☐ *Repairs*

Tooth Number(s): ______________ Tooth Shade: ______________

☐ Other: ______________________________

Removable Devices *(precise instructions below)*:

☐ Thermoplastic Night Guard
☐ Proform Night Guard
☐ Dual Laminate Night Guard (soft inside/hard outside)
☐ Essix Retainer ☐ Essix Retainer (3D printed)
☐ Sports Guard
☐ Bleaching Tray ☐ Spacer
☐ Other: ______________________________



Precise Instructions:

Professional Signature: ______________________________

Please send scans (STL format) to email: **cases@crehsinc.com**