# HAWLEY ORTHODONTIC LABORATORY
# RETURN SLIP

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| | |
|---|---|
| PATIENT NAME: | PATIENT LAST NAME |
| PRACTICE NAME: | DOCTORS NAME: |

| | | | | |
|---|---|---|---|---|
| ADDRESS: | SUITE: | CITY: | STATE: | ZIP: |
| PHONE: | EMAIL: | | | |
| DOCTORS LICENSE#: | SIGNATURE: | | | |

## REASON FOR RETURN

(CHECK ALL THAT APPLY)

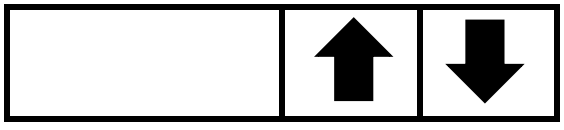
**REMAKE:** ☐ **REPAIR:** ☐

**MODELS WORKED:** **UPPER:** ☐ **LOWER:** ☐ **BOTH:** ☐

**LAB CODE ON MODEL:** _____

**DESCRIPTION:**

## LAB USE ONLY

| | | |
|---|---|---|
| **RECEIVED** | DATE: | BY: |
| **REVIEWED** | DATE: | BY: |
| **APPROVED** | DATE: | BY: |

**COMMENTS:**