



**SOL**  
Simply Ortho Lab

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ABN: 52 356 841 633

Dentist:  
Address:  
Phone:

DATE / TIME DUE:

### INDIRECT BONDING LAB SHEET

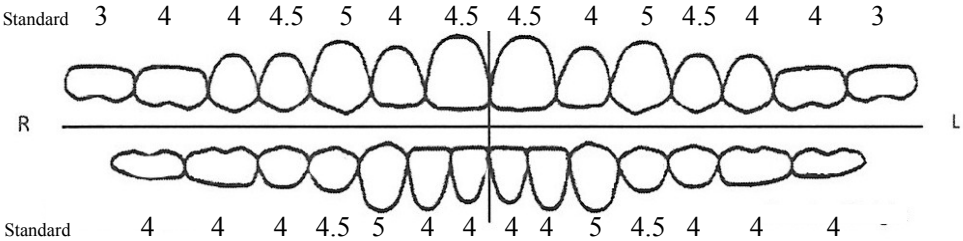
PATIENT NAME: \_\_\_\_\_

**Circle:**            Upper                      Lower

**Circle:**            Custom Pads (Transbond XT)    YES                      NO

**Circle:**            Full Arch                      Midline Split                      Three Sections

Please indicate custom height if required. If no height indicated, brackets will be placed at Standard heights as shown.



SPECIAL INSTRUCTIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIOR TO PACKING: Please ensure brackets are enclosed, models or impressions are carefully wrapped and lab sheet is completed including due date**

Dentist Signature \_\_\_\_\_